NGO NETWORKS FOR HEALTH (*NETWORKS*)
TECHNICAL APPROACH TO BEHAVIOR CHANGE PROGRAMS

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EXECUTIVE SUMMARY

Introduction

NGO Networks for Health (*Networks*) is a five-year, USAID-funded partnership which combines the resources of five NGOs for the purpose of improving family planning, reproductive health, child survival and HIV practices and services in selected countries. The five partners are the Adventist Development and Relief Agency (ADRA), the Cooperative for Assistance and Relief Everywhere (CARE), the Program for Appropriate Technology in Health (PATH), Plan International, and Save the Children/US.

Behavior change is a major focus of *Networks* mandate, figuring prominently in the organization's strategic objective—the increased use of family planning, reproductive health, child survival, and HIV (FP/RH/CS/HIV) practices and services through enhanced capacities of PVO/NGO networks—and in two of the four results of its Results Framework. In Result 1 (Sustained PVO capacity to provide quality FP/RH/CS/HIV services), the emphasis is on organizational change, and in Result 2 (Accurate knowledge and sustained behavior change at the community level) on change at the community level, the focus of this document.

Networks itself does not carry out behavior change programs; rather, it supports the programs of the five Partners in focus countries. This paper, accordingly, is not a blueprint for carrying out specific behavior change programs but is a position paper that outlines key guiding principles and a strategic framework for designing and implementing these kinds of programs.

Networks Philosophy

The *Networks* approach to behavior change is community-centered with a focus on empowerment and the ultimate aim of promoting social change. It therefore embraces the concepts of partnership, participation, empowerment, human rights, and the promotion of the community's assets. This approach is informed and guided by a number of key lessons learned in health promotion programs over the years. Recommended program directions, which are drawn from the most important lessons learned, are summarized below.

1) **Behavior change is an individual <u>and</u> a group process and is part of the larger process of social change.**

   Many prominent behavior change theories are from social and clinical psychology and are individual-focused linear models. They often have limited use when considering HIV transmission and other public health issues in developing countries, mainly because these models do not sufficiently take into account the cultural and social contexts in which individuals make decisions and take action. While individual change is important, an individual's behavior is affected and prompted by group or other social influences. Recognizing this, *Networks* will focus on theories and programs that are concerned with group and social change.

2) **Behavior change programs should reposition "target audiences" and "beneficiaries." They should be partners who are the agents of their own change and not objects of change.**

   Health related information, education, and communication (IEC) and behavior change communication programs have positioned those whom the programs are intended for as "target audiences" or "beneficiaries." This approach has placed the emphasis on the outside "expert" who knows what will work best. *Networks* behavior change programs will position "beneficiaries" as partners who are rational and creative beings who can, with the right tools, identify their own problems, find solutions, and mobilize the needed resources. Rather than trying to persuade people to do something, *Networks* will aim to promote critical thinking and negotiate the best way forward in a partnership process.

3) **Sound public health knowledge alone is not sufficient to bring about behavior change. Social, economic, and political factors are also important.**

   There is often a gap between public health knowledge and practice, which indicates that while this knowledge plays an important role in behavior change, it does not necessarily predict behavior. Other social, economic, and political factors greatly influence people's behaviors that affect their health status. *Networks* behavior change programs will, therefore, have a two-pronged approach. They will provide accurate public health information but will also aim to create enabling environments that promote the adoption and maintenance of behaviors that enhance people's health status.

4) **Using the community's own resources, its knowledge and its assets, increases the likelihood that behavior change will be sustained.**

   Many development programs have concentrated on bringing needed resources from outside the community to address health and other development issues. More recently, however, those implementing development programs are looking within the community for answers, recognizing that the community's knowledge and assets can be used as solutions are more sustainable than the ones that outsiders or "experts" bring. *Networks* will take into account community knowledge and information and promote assets, resources, and strengths within the community to address health issues.

5) **Behavior change programs should respond to explicit or latent demands which already exist in the community.**

   Networks believes in linking behavior change programs to existing needs in the community, whether recognized or unrecognized. In the latter instance, the focus of the program will be more on helping people articulate their needs and identify their own solutions.

6) **Service providers must be empowered if they are to adequately address the needs of their clients and offer quality health services.**

   In most health facilities throughout the world, service providers feel helpless and powerless to effect changes within the larger health system. They are often underpaid, overworked, lack essential supplies, and feel unappreciated. They do not believe that they can make things different. Yet, they are expected to address the needs of their clients and provide quality health services. *Networks* programs will aim to empower service providers so that they can effect changes within their system and thereby be better able to address the needs of their clients.

7) **To ensure quality and adequate use of health services, dialogue with the community must be fostered. Service providers and the community should define quality together.**

   Health seeking behaviors depend on a number of factors but the perceived quality of care is key to whether people use health services or not. But who defines quality of care? Usually it is the health planners and providers who define quality, which they do within the biomedical paradigm instead of the larger socio-cultural context or paradigm. *Networks* will foster dialogue between the health providers and the community that they serve so that they both can define quality together and thereby enhance mutual understanding, improve the service providers' respect for their clients, and increase the clients' feelings of ownership of services.

Networks Approach

As noted earlier, *Networks* itself does not carry out behavior change programs; rather, it supports its Partners in focus countries as they design and implement their own programs. The *Networks* approach encourages Partners to begin with a series of assessments to gather information about health conditions and prevailing health practices in program areas. *Networks* recommends three different assessments:

1) An epidemiological assessment to identify the most serious, frequent, and preventable causes of illness and death;

2) A social or quality of life assessment which seeks the community's (households, health facilities, key stakeholders) views of major health problems, making use of a number of key methodologies, including community diagnosis, participatory rural appraisal, and stepping stones); and

3) A behavior and lifestyle assessment which seeks to identify which behaviors in the community perpetuate health problems and which behaviors prevent them.

These assessments will enable focus country networks partners and their community partners to identify priority health needs around which they can then begin to design programs. Depending on circumstances, *Networks* will advise and support country staff in any or all of the following tasks related to program design and delivery:

- Designing program goals and objectives
- Designing program strategies
- Identifying needs for technical assistance and how to meet them
- Creating a communication plan
- Creating an advocacy plan
- Creating a training plan
- Identifying roles and responsibilities of key players
- Conducting an inventory of local resources
- Deciding how resources will be mobilized
- Developing a monitoring and evaluation plan

Networks anticipates using a mix of technical approaches to behavior change, as no one approach is appropriate for all contexts, audiences, and strategies. Given our focus on behavior change in the context of community empowerment and long-term social change, we prefer approaches that are likely to lead to social mobilization. We define social mobilization as a series of planned or spontaneous actions and processes that reach, involve, and influence all relevant segments and sectors of society from community to the national levels, to create an enabling environment that effects and supports positive behavior and social change. The four specific technical approaches to promote social mobilization are community mobilization, communication for social change, policy advocacy, and social marketing.

At the heart of all four of these approaches, and of *Networks* community-centered, empowerment philosophy—and, indeed, of all behavior change—is communication. *Networks* recommends using a variety of communication channels, including: interpersonal communication, counseling, print, popular media (theater, puppet shows, songs, dances), and electronic and other types of mass media.

Networks will implement its behavior change strategy in seven steps:

1) Study how Partners in focus countries design and carry out behavior change at the national level.

2) Study how other focus country networks approach behavior change.

3) Bring representatives from the Partners and other networks together in a meeting to discuss the advantages and possibilities of collaboration. Specifically, participants will discuss each other's successes and resources, review the *Networks* technical approach, outline a common approach making use of combined resources, design implementation strategies for local contexts, identify capacity-building needs, and review and revise existing communication materials.

4) Analyze, together with focus country staff, how programs will be implemented, how the qualitative research will be done (and linked to the overall M&E plan).

5) Work with focus country staff to identify technical assistance needs and to outline a plan for building capacity.

6) Periodically update (with focus country staff) the local USAID mission on the progress of behavior change programs.

7) Sponsor a number of ongoing support activities, such as compiling and disseminating generic tools and guides and establishing forums for discussion and sharing information.

ACRONYMS

ADRA	Adventist Development Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
CARE	Cooperative for Assistance and Relief Everywhere
CS	Child Survival
DFID	Department of Foreign International Development (UK)
FGC	Female Genital Cutting
FP	Family Planning
HIV	Human Immunodeficiency Virus
KAP	Knowledge Attitudes and Practices
NGO	Nongovernmental organization
NSMP	Nepal Safer Motherhood Project
PATH	Program for Appropriate Technology in Health
PVO	Private Voluntary Organization
RH	Reproductive Health
USAID	United States Agency for International Development

INTRODUCTION

Background

The NGO Networks for Health project (*Networks)* is a five-year, USAID-funded cooperative agreement implemented by a partnership of five non-governmental organizations (NGOs)[1]: the Adventist Development and Relief Agency (ADRA), the Cooperative for Assistance and Relief Everywhere (CARE), the Program for Appropriate Technology in Health (PATH), Plan International, and Save the Children/US. *Networks* operates under the assumption that current family planning (FP) and other reproductive health (RH)[2], child survival, and HIV/AIDS services cannot meet the projected demand for these services. The project will address the growth in demand for information and services by expanding service delivery through new collaborative approaches such as networks and partnerships of NGOs, public sector agencies, and other private sector organizations.

Networks mandate is to:

- Increase the capacity of our five Partners to carry out high quality FP/RH/CS/HIV programs more collaboratively.
- Develop 4-8 focus country networks among PVOs, NGOs, and public and other private sector providers to increase provision of FP/RH/CS/HIV information and services among 10-20 percent of the client population in each country and/or project area.

In addition, *Networks* expects that the project will improve the ability of its Partners to increase the quality and collaborative nature of FP/RH/CS/HIV programming in other countries where they work.

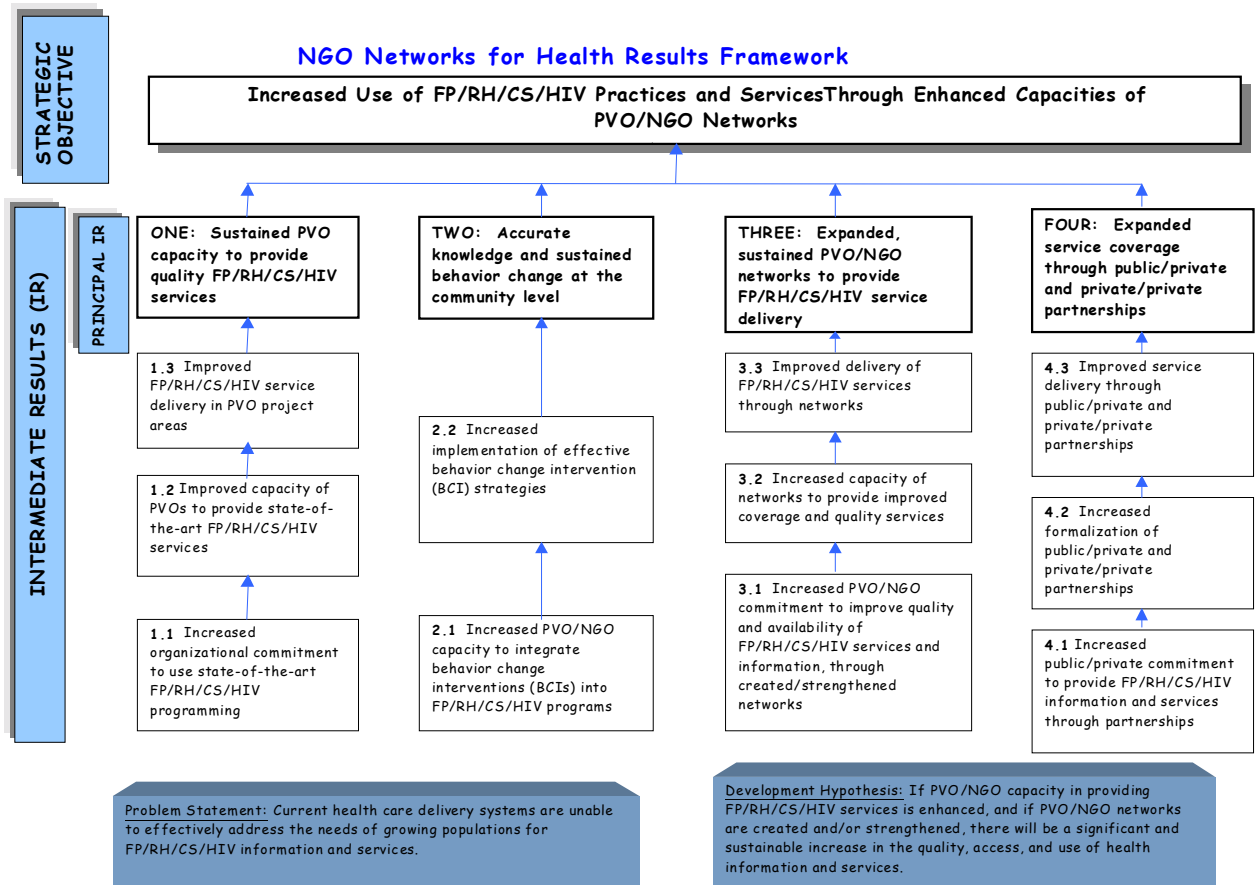
The Role of Behavior Change within *Networks*

Behavior change plays a pivotal role within *Networks*. Attaining the project's strategic objective—*increased use of family planning, reproductive health, child survival, and HIV (FP/RH/CS/HIV) practices and services through enhanced capacities of PVO/NGO Networks*—depends on several factors. Behavior change, both at the organizational and community levels, is a key one. Of the four results in the *Networks* Results Framework (see Figure 1), Results 1 and 2 relate to behavior change. Result 1, which has as its mandate the capacity building of the Partners, addresses behavior change at the organizational level. It includes strategies to assist each of the Partners to develop and implement an appropriate vision and "change strategy" for building commitment and capacity in FP/RH/CS/HIV service delivery. This document, which is a product of Result 2, focuses on behavior change at the community level.

[1] Also known as private voluntary organizations or PVOs.

[2] In this document and in this project, the term *reproductive health* includes *Safe Motherhood.* Family planning, HIV/AIDS and other sexually transmitted infections are represented under separate headings.

FIGURE 1 – NGO Netowrks for Health Framewor


NGO Networks for Health Results Framework
STRATEGIC OBJECTIVE
Increased Use of FP/RH/CS/HIV Practices and ServicesThrough Enhanced Capacities of PVO/NGO Networks
INTERMEDIATE RESULTS (IR)
PRINCIPAL IR
ONE: Sustained PVO capacity to provide quality FP/RH/CS/HIV services
TWO: Accurate knowledge and sustained behavior change at the community level
THREE: Expanded, sustained PVO/NGO networks to provide FP/RH/CS/HIV service delivery
FOUR: Expanded service coverage through public/private and private/private partnerships
1.3 Improved FP/RH/CS/HIV service delivery in PVO project areas
1.2 Improved capacity of PVOs to provide state-of-the-art FP/RH/CS/HIV services
1.1 Increased organizational commitment to use state-of-the-art FP/RH/CS/HIV programming
2.2 Increased implementation of effective behavior change intervention (BCI) strategies
2.1 Increased PVO/NGO capacity to integrate behavior change interventions (BCIs) into FP/RH/CS/HIV programs
3.3 Improved delivery of FP/RH/CS/HIV services through networks
3.2 Increased capacity of networks to provide improved coverage and quality services
3.1 Increased PVO/NGO commitment to improve quality and availability of FP/RH/CS/HIV services and information, through created/strengthened networks
4.3 Improved service delivery through public/private and private/private partnerships
4.2 Increased formalization of public/private and private/private partnerships
4.1 Increased public/private commitment to provide FP/RH/CS/HIV information and services through partnerships
Problem Statement: Current health care delivery systems are unable to effectively address the needs of growing populations for FP/RH/CS/HIV information and services.
Development Hypothesis: If PVO/NGO capacity in providing FP/RH/CS/HIV services is enhanced, and if PVO/NGO networks are created and/or strengthened, there will be a significant and sustainable increase in the quality, access, and use of health information and services.

Purpose of the NGO Networks Technical Approach to Behavior Change Programs Document

This document describes *Networks* behavior change technical approach and sets forth guiding principles and a strategic framework for the design and implementation of behavior change programs in our focus countries. *Networks* itself does not carry out behavior change programs; it is our Partners in the field who design and implement these programs at the country level, based on specific program goals, local needs, context, and available resources. This document, therefore, is not meant to be a detailed implementation plan or a "how to" manual. It is, rather, a position paper and guide.

GUIDING PRINCIPLES FOR *NETWORKS* BEHAVIOR CHANGE PROGRAMS

Community organization continues to play a pivotal role in health education, health promotion, behavior change programs, and related disciplines. It also fits philosophically with most of the fundamental principles of effective community health education and other social change approaches (60,76). The guiding principles of the *Networks* project, therefore, are based on community organization and embrace the concepts of partnership, participation, empowerment, human rights, the promotion of the community's assets, and social change (Appendix A).

Since *Networks* will be addressing behavior change within the context of social change, the behaviors that change are likely to be more than just those relating to reproductive and child health (see Appendix B for an illustrative list of program indicators related to actions or behaviors promoted by the Project). They will also be behaviors relating to community capacity building and empowerment, such as identifying problems, finding solutions, and mobilizing resources.[3]

The guiding principles for the *Networks* technical approach to behavior change programs are as follows:

- Behavior change programs will be community-centered and promote the empowerment of community partners through increased knowledge, skills, supportive social relationships, and links to external resources. NGOs and other implementing partners, who are outside the community, will be encouraged to limit their role to that of facilitator.

- Behavior change interventions will be developed by the community to promote ownership and reflect stakeholder[4] needs and values through the use of participatory research and action methodologies.

- The participation of stakeholders will be central to monitoring and evaluation of behavior change interventions and programs. Both process and outcomes will be valued and evaluated.

- All programs will address gender equity, empowerment of women, and include a human rights perspective.

- All programs will increase access to health care for those who are marginalized due to poverty, gender, caste, religion, ethnicity, age, or other socio-cultural reasons.

[3] Ronald Labonte in a keynote speech at the Consultative Forum on Behavior and Social Change, April 13-14, 2000, pointed out that behavior change was inherent in community capacity building.

[4] Stakeholders can include community members, grassroots organizations, NGOs, service providers, and members of municipal, provincial, and national governments.

- A focus on existing strengths within communities will be promoted through an assets-based approach. Critical thinking processes will be incorporated as a means of building requisite community capacity for action.

- Behavior change programs will promote positive behavior change in the context of social change using five basic approaches: social and community mobilization (Appendix A), communications for social change, advocacy, and social marketing.

PROGRAM RECOMMENDATIONS

A review of the health promotion literature reveals a variety of lessons learned in the past in designing and implementing behavior change programs. Program recommendations, which are drawn from the most important lessons learned, are summarized below.

Program Recommendation #1: Behavior change is an individual and a *group* process and is part of the larger process of social change.

Program Recommendation #2: Behavior change programs should reposition "target audiences" or "beneficiaries." They should be positioned as partners who are the agents of their own change—not objects of change.

Program Recommendation #3: Sound public health knowledge alone is not sufficient to bring about behavior change. Social, economic, and political factors are also important.

Program Recommendation #4: Using the community's own resources, its knowledge and its assets, increases the likelihood that behavior change will be sustained.

Program Recommendation #5: Behavior change programs should respond to explicit or latent demands which already exist in the community.

Program Recommendation #6: Service providers must be empowered if they are to adequately address the needs of their clients and offer quality health services.

Program Recommendation #7: To ensure quality and adequate use of health services, dialogue with the community must be fostered. Service providers and the community should define quality together.

Program Recommendation #1

> *Behavior change is an individual and a group process and is part of the larger process of social change.*

Many of the major theories for health promotion are primarily from social and clinical psychology (Appendix C). They are individual-focused linear models which predict health behavior through a collection of cognitive and sometimes also logistical variables, which are generally treated as separate, non-interacting factors (55). These include the Stages of Change Model (55,85,86,99), the theory of reasoned action (85,86,99), the Health Belief Model (55,85,86,99), social learning theory (55,85,86,99), the AIDS Risk Reduction Model (86), and others. While some interventions aimed at effecting behavior change at the individual level have succeeded, growing evidence indicates that some of the models may have limited use when

considering social and environmental determinants of HIV transmission (72) and other public health issues in developing countries. The reason is that these determinants often go beyond individual volition and require collective efficacy (3,4,72). Another reason may be that the concept of the individual does not exist in some cultures or is secondary to the group or community (11,12). That is why it is important to examine social change models, such as the Diffusion of Innovations Theory, the Social Network Theory, and Social Change Theories, which look at how an individual's behavior is shaped by his/her social context (Appendix C).

The Diffusion of Innovations Theory and the Social Network Theory emphasize the importance of social networks. The former explores how innovations or ideas are spread from person to person, and from one community or society to another. The latter goes further to examine how social groups influence an individual and his/her behavior. Social Change Theories recognize the influence of local values, norms, and social behavior on individual behavior.

What this means for Networks behavior change programs

While *Networks* recognizes the importance of individual change, its focus will be on theories and programs that are concerned with group and social change (Appendix C).

Some operational questions to consider

- What is the potential for group action on a particular health concern?
- What are the strategies that would encourage collective efficacy and group action?

A SOCIAL MOVEMENT THAT LED TO THE BANNING OF FEMALE GENITAL CUTTING (FGC) IN SENEGAL—A CASE STUDY

A group of village women in Senegal, who had been exposed to a one-year modularized training program that taught literacy, problem-solving, self-awareness, and assertiveness skills through guided group discussions, mobilized their community to abolish Female Genital Cutting (FGC), which they felt was against their human rights. Since September 1996, when this village of *Malicounda Bambara* publicly declared that it would refrain from FGC, an event known as the *Oath of Malicounda*, more than 104 villages—some of which have marriage ties—decided that they would ban FGC. The men who were mobilized traveled from village to village. They originally feared being chased out of many communities but instead they discovered that the news of *Malicounda* opened doors and hearts as women who had shocking stories wanted to speak out. Thus, the men became more committed to the cause. This multiplier effect and social movement emboldened the Government of Senegal to work towards passing a law to make the practice illegal.

The one-year training program used in Malicounda Bambara was implemented by TOSTAN ("breaking out of the egg" in the local language, *Wolof*), a Senegalese NGO. It aims to link literacy to life skills and covers topics such as sanitation, disease prevention, women's health, child health, human rights, project planning and implementation, and book-keeping techniques. This case study shows how a group of village women with the right tools mobilized themselves and the men in their community around the issue of FGC. These men and women were able to go on and mobilize other communities until their work took on the dimensions of a national social movement. TOSTAN only provided them with the tools, skills, and logistical support.

From:
NGO Networks for Health. *The Challenge: Rethinking Behavior Change Interventions in Health*, 1999.
IK Notes World Bank No. 3, December, 1998.
TOSTAN, *Breakthrough in Senegal, Ending Female Genital Cutting*, A report funded by The Population Council, 1999.

Program Recommendation #2

> *Behavior change programs should reposition "target audiences" or "beneficiaries." They should be positioned as partners who are the agents of their own change—not objects of change.*

Development efforts have recently begun to move away from the premise that people are objects for change to the realization that people and communities are the agents of their own change (33, 18,19,20,52,62,77,80,81). This change in thinking has also resulted in a shift away from conveying information from technical experts to sensitively placing that information into the dialogue and debate within the community and among other partners (33, 18,19,20,77,80,81). Efforts like the USAID-funded Quality Assurance Project have recognized that in training service providers it is important to equip them with analytical skills in addition to the technical knowledge that had previously been the sole focus of similar projects (28,32).

The work of TOSTAN (cited above) shows how village women with the right tools became agents of their own change. The training TOSTAN provided gave the Senegalese women the critical thinking skills they needed to recognize that FGC was against their human rights and to mobilize to stop the practice. They started a social movement which as been sustained.

SUSTAINABLE CHANGE—THE SOCIAL MOVEMENT THAT LED TO THE BANNING OF FEMALE GENITAL CUTTING (FGC) IN SENEGAL CASE STUDY—A CONTINUATION

During the time of the *Malicounda* pledge, one reporter asked the women if they would stick to their decision to end FGC. Everyone was perplexed at this question. "Why make a declaration if you are not going to go through with your decision?" they responded.

"It's a question of honor," said one older woman in *Manpatim* in the Kolda region, "And besides why in the world would we go back on that decision now? My ancestors spent much of their time drinking palm wine and now no one would ever dream of consuming alcohol in this village! Change is not that difficult when it's in your best interest!"

After TOSTAN equipped these women with critical thinking skills and tools within the context of human rights, women mobilized around other socioeconomic issues. When they learned that owning land was a human right, for example, these women, who had been landless, mobilized and obtained land from male elders to start community gardens. When they learned that education for girls was a human right, they advocated for additional schools to be built and serviced so that their daughters could be educated. This case study clearly illustrates that if you develop people's ability to think critically, they can apply that skill to various aspects of their lives in an ongoing, sustainable process.

From:
TOSTAN, *Breakthrough in Senegal, Ending Female Genital Cutting*, A report funded by The Population Council, 1999.

What this means for Networks behavior change programs

A key *Networks* assumption is that "beneficiaries" are really partners. They are rational and creative beings who can, with the right tools, identify their problems, find solutions, and mobilize the necessary resources. Rather than trying to persuade people to do something, *Networks* will aim to promote critical thinking and negotiate the best way forward in a partnership process.

Some operational questions to consider

- What skills do community members need to develop so that they can identify problems, find solutions, and mobilize the necessary resources? What tools can they use?
- What are the strategies that can be used to develop community capacity to address needs?

Program Recommendation #3

> *Sound public health knowledge[5] alone is not sufficient to bring about behavior change. Social, economic, and political factors are also important.*

While public health knowledge plays an important role in behavior change, it is not necessarily a predictor of behavior. In many countries significant numbers of women know about modern contraception, for example, but do not use a family planning method (57,58). In Malawi, the 1996 Demographic Health Survey revealed that 96 percent of married women knew of at least one modern method of family planning; yet the contraceptive prevalence rate among married women for modern methods is 14 percent (56). This discrepancy between knowledge, attitudes, and practices (KAP), called the "KAP GAP," highlights the fact that there are factors besides being informed that determine an individual's ability to adopt and maintain a new behavior or stop engaging in a risky one.

Other determinants which help or hinder behavioral choice have been categorized in a number of ways. The model developed by UNAIDS uses the contextual categories or domains of government policy, socioeconomic status, culture, gender relations, and spirituality (2).[6] Others have looked at determinants within the context of structural and environmental factors (86), which include the following:

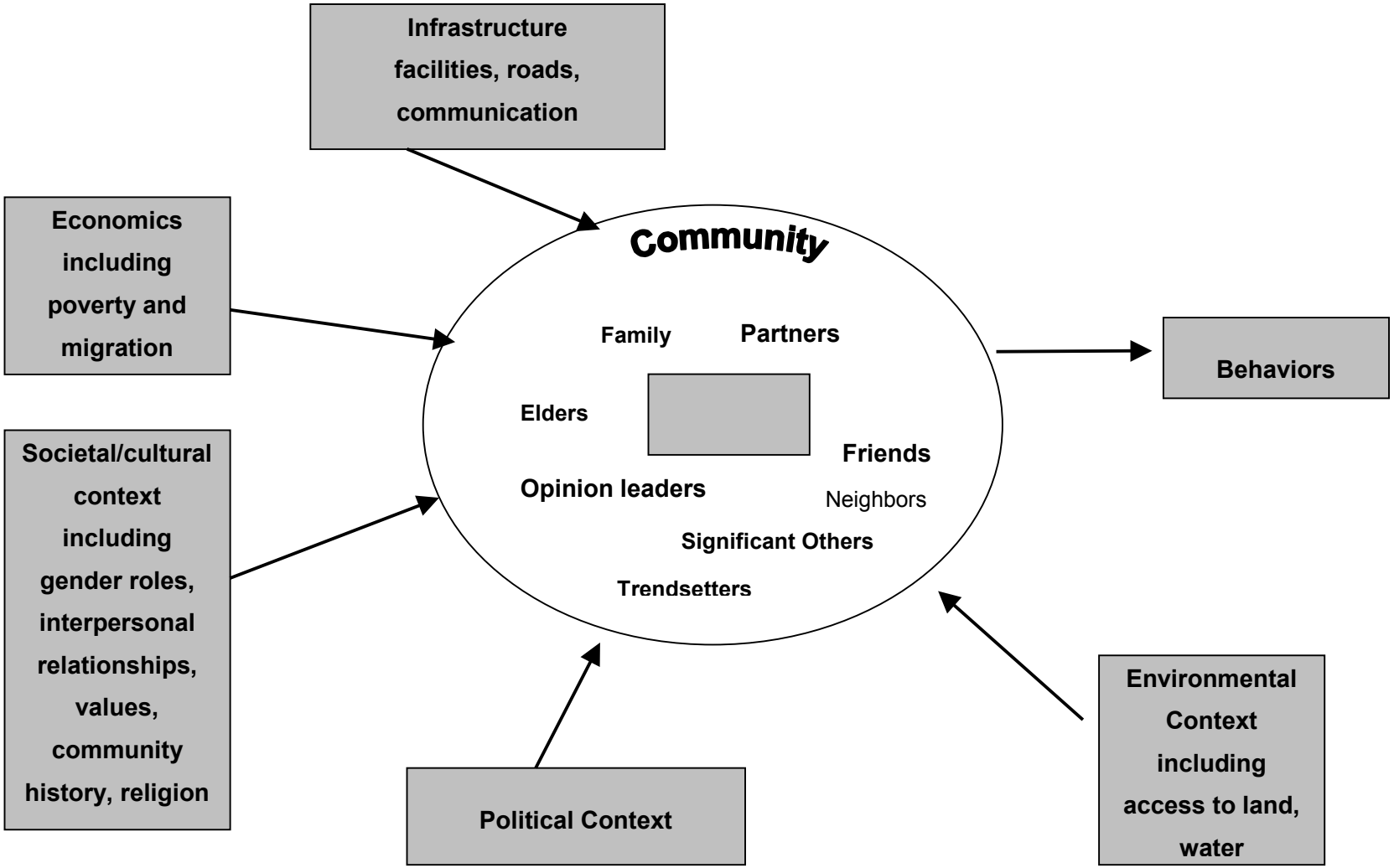
- superstructural (poverty, gender, ethnicity, traditional practices);
- structural (laws, policies);
- environmental (living conditions, resources, social pressures and opportunities);
- individual (isolation, low perception of risk).

Figure 2 presents a model that illustrates some of the community-level determinants of individual behavior.

[5] Public health knowledge is used here to differentiate between biomedical knowledge and other types of knowledge such as community knowledge. Other types of knowledge can also lead to behavior change. For example, Uganda's AIDS Information Centre found that those who knew their HIV status increased their use of condoms (94).

[6] Some anthropologists argue that gender and spirituality are a part of culture.

FIGURE 2 – Model of Community-Level Determinants of Individual Behavior



Adapted from FHI/AIDSCAP

What this means for Networks behavior change programs

In addition to providing accurate public health information at the community level, *Networks* behavior change interventions and programs will aim to create enabling environments that promote the adoption and maintenance of behaviors that enhance people's health status. Some of the key factors that need to be addressed to create enabling environment for people to adopt and maintain healthy behaviors or access health services include policy, poverty, gender, and religion. Building skills or efficacy (3,4) will also be a component of creating enabling environments.

Some operational questions to consider

- What public health knowledge does the community have on the specific health issue? How accurate is this knowledge? How does this knowledge relate to local practices?
- What are the health practices that directly affect people's health status?
- Why do they do what it is that they do? Why don't they do what it is that they need to do to be healthy?
- What are the community assets, resources, and strengths that can either help people overcome practice healthy behaviors?

IMPLEMENTATION OF THE 100% CONDOM PROGRAM IN THAILAND—A CASE STUDY

In response to growing HIV seroprevalence among low-fee commercial sex workers in northern Chiang Mai, the Government of Thailand established the 100 percent condom program in 1989. Recognizing that the commercial sex workers did not have the power to refuse sex without a condom, this ambitious and innovative effort enforced universal condom use in all commercial sex establishments. By 1994, over 90 percent of commercial sex acts were protected by condoms, and the number of commercial sex workers and men presenting at government clinics with an STD declined significantly. An evaluation indicated that before the intervention, only 42 percent of women surveyed by volunteers posing as clients refused to have sex without a condom, even when offered three times the usual fee. Following the program, 92 percent of the women refused sex without a condom. This case study shows that condom usage increased significantly in brothels because gender and power relationships were addressed by the policy that was introduced. It was the brothel owners who were made responsible for ensuring condom use in their establishments—not the sex workers, who would have had little or no power to make their clients use a condom. But it should be noted that the program was successful because all the brothel owners implemented the policy.

From:
Visrutaratna, S. et al. "Superstar" and "model brothel": developing and evaluating a condom promotion program for sex establishments in Chiang Mai, Thailand, *AIDS,* 9 Suppl 1:S69-75, 1995.
Wiwat, R. and Hanenberg, R. The 100% condom programme in Thailand (editorial review), *AIDS*, 10:1-7, 1996.
Hanenberg, R.and Rojanapithayakorn, W. Prevention as policy: how Thailand reduced STD and HIV transmission, *AIDSCAPTIONs,* May: 3(1):24-7, 1996.

Program Recommendation #4

> *Using the community's own resources, its knowledge and its assets, increases the likelihood that behavior change will be sustained.*

Many development efforts have concentrated on bringing needed resources from outside the community to address health and other development problems. More recently, however, those implementing development programs are looking within the community for answers, recognizing that using the community's own knowledge and assets creates more sustainable solutions than using the resources of outsiders or "experts" (60,76,82,83).

USING COMMUNITY KNOWLEDGE TO COMBAT MALNUTRITION IN VIETNAM—A CASE STUDY

Malnutrition was a problem in some parts of Vietnam. Working closely with residents of several villages in Thanh Hoa province, Save the Children/US first identified very poor families who had managed to avoid malnutrition. The parents in these families had access to no more resources than their neighbors, yet they found enough food to keep their children healthy. By examining the behavior of these people, known as *positive deviants,* Save discovered that the mothers in these families fed their children tiny shrimps and crabs (collected from nearby paddies) and sweet potato greens. They also fed their children three or four times a day, instead of twice a day as was customary. Since the shellfish and greens were both readily available, it was clear that the solution to the malnutrition problem did not require a lot of money or other outside resources; it simply required community members to change their behavior and to start emulating the *positive deviants* in their midst. It should be noted, however, that *positive deviance* works best where absolute food deprivation is not the key constraint to improved nutritional status.

Building a project based on this insight, the rates of child malnutrition in the Thanh Hoa province declined. Within two years, 80 percent of the children who participated in the project were no longer malnourished. This model was subsequently used in 20 Vietnamese provinces. In some, the key foods were shellfish and greens, but in others they were peanuts or sesame seeds or dried fish. The community, in other words, had the answers.

From:
Sternin, J. and Choo, R. The Power of Positive Deviancy, *Harvard Business Review,* January-February 2000.
Sternin, M. et al Scaling Up a Poverty Alleviation and Nutrition Program in Vietnam, *High Impact PVO Child Survival Program, Volume 2,* Save the Children, 1999.

DIALOGUE WITH A COMMUNITY IN KENYA RESULTED IN THE COMMUNITY FINDING AN ALTERNATIVE TO FGC AS A RIGHT OF PASSAGE — A CASE STUDY

With technical assistance from PATH, *Maendeleo Ya Wanawake*, an NGO in Kenya, found in their initial research that adolescent girls valued the recognition from peers and adults and the gifts and other privileges associated with traditional circumcision ceremonies. In partnership with the community, an alternative one-day coming of age celebration was established, which included poem recitals, anti-FGC songs, feasting, dancing, and gift giving. Since August 1996, over 1,500 girls went through the alternative rite of passage instead of undergoing FGC. The group of mothers who participated in the first ceremony registered themselves as an NGO called *Ntaniro Na Mugambo*, which means "circumcision with words," and are implementing the program throughout the district. Other agencies have also adopted the alternative rite of passage as a program priority in Kenya, where it promises to be sustainable. This case study illustrates how a community, if it is engaged in the dialogue, can find acceptable alternatives to harmful traditional practices.

From:
NGO Networks for Health. *The Challenge: Rethinking Behavior Change Interventions in Health*, December 1999.

What this means for Networks behavior change programs

Networks will take into account community knowledge and information and promote the assets, resources, and strengths within the community to address health issues.

Some operational questions to be considered

- What is the existing community knowledge and information on the specific health issue?
- Are there any groups of people with the same socio-demographic profiles as the ones with the health problems in the community who have better health outcomes? If so, what are they doing differently?
- What interventions are necessary for other community members to learn from the "positive deviants" and adopt their healthy behaviors?
- With respect to traditional harmful practices, what is the significance behind a traditional practice that can be harmful?
- How can the positive aspects of a cultural practice be delineated from the harmful aspects? Are there alternatives to the harmful practice? If so, what are they?
- What would be the best way to engage the community in dialogue to identify alternative practices?

> "If I listen long enough, they will tell me what I was going to say. If I keep quiet longer, they will tell me what I didn't know, and I learn." — *Jay Edison, ADRA*

Program Recommendation #5

> *Behavior change programs should respond to explicit or latent demands which already exist in the community.*

Whether interventions should create demand or channel existing demand, be it latent or explicit, is hotly debated. Those who design and implement integrated marketing communication programs, for example, have pointed out that marketing is not about creating need but about finding a solution to an already existing need or desire. They point out that if a program focused on getting that segment of a population that expresses an unmet need for family planning to the services, then the contraceptive prevalence rates would increase significantly (41,42).

In 1996, for example, 26 percent of married Zambian women were using a family planning method (14 percent were using a modern method while 12 percent were using a traditional one). But another 26 percent of married Zambian women had an unmet need for family planning, that is, they either wanted to delay pregnancy or wanted no more children but were not using a family planning method. If the 26 percent of women with an unmet need could be linked to family planning services, the contraceptive prevalence rate would increase by 100 percent!

Cultures and societies are dynamic and not static; change occurs continuously. Recognizing this, those working in advocacy or changing harmful traditional practices (59,63) feel it is important to empower people with the appropriate tools to exert influence over the direction of social change. Often, the need for change already exists in a community. The people may not be able to articulate this need or the need may be subconscious, but when they realize their options, they recognize their own needs for change. The TOSTAN experience in Senegal is an example of this lesson. When the village women were made aware of their human rights, they realized that FGC was against those rights and mobilized to stop the practice.

What this means for Networks behavior change programs

Networks will look for opportunities to address existing need for healthy behaviors or link existing demand to health services.

Some operational questions to consider

- Is there a latent need for changing a particular behavior? How can this latent need be mobilized to effect positive change?
- What is the unmet need for health services?

Program Recommendation #6

> *Service providers must be empowered if they are to adequately address the needs of their clients and offer quality health services.*

In most health facilities throughout the world, service providers feel powerless to make changes within the bureaucracy of a large health system (69,70). They are often underpaid, overworked, lack essential supplies, and feel unappreciated. They do not believe that they can make a difference. Yet, they are expected to address the needs of their clients and provide quality health services. Some programs have successfully embarked on empowering health workers first so that they are better able to address the needs of their clients (34,69,70).

What this means for Networks behavior change programs

Networks will identify strategies that empower service providers so that they are better able to take care of their clients' needs.

Some operational questions to consider

- How can the realization that change is needed be accomplished?
- How can a vision of what is possible be created?
- What are some of the obstacles to the vision? How can these be removed?
- How can those involved in the change be encouraged and kept energized?
- How can leadership be developed and supported?

EMPOWERING HEALTH WORKERS IN NEPAL IMPROVED THE QUALITY OF HEALTH SERVICES —A CASE STUDY

The Nepal Safer Motherhood Project (NSMP), implemented by the UK-based Options Consultancy Services Limited on behalf of DFID, aims to increase utilization of quality emergency obstetric life saving care. But to provide this care at the participating district hospitals, it was necessary to develop and implement a strategy to address the common fatalistic belief that the future is predetermined by karma. This belief is often referred to as *Ke garn*e, which translates as "Don't give yourself a headache because nothing can change." As a result of the resource poor situation and this fatalistic view, employees within many Nepali government institutions suffer from deep cynicism and apathy. They do not see how they can change things for the better and improve the quality of the services they offer.

The NSMP decided to develop a new vision in district hospitals. All staff, including administrative and support staff, participated from the beginning in identifying the needed changes and created a vision that was owned by all. A key principle was that the vision could be communicated to someone in five minutes or less. The details are as follows:

By the end of Phase One, the three district hospitals will be able to offer 24 hour Comprehensive Emergency Obstetric Care in an environment which is:

- Safe and clean.
- Adequately and appropriately equipped.
- Has a woman and family focus.
- Staffed by personnel who are committed to working as a team to improve maternal health.
- Managed by staff confident and competent to treat obstetric emergencies appropriately.

The vision not only provided the rationale for the transformation of the hospital, but the process of creating the vision, which was based on the appreciative inquiry methodology, resulted in the hospital staff collectively identifying positive factors and strengths in the working environment. It also led to the implementation of "breakthrough" projects to achieve the vision, including the introduction of the partograph,[7] a scheme to support vulnerable women and the development of local reproductive health protocols. Systems to recognize the achievements of the staff were developed, including merit award schemes. So that the program did not lose momentum, the urgency for change was illustrated by creating a time line that was adhered to.

The project has resulted in the staff taking pride in the transformation of the hospital and the quality services that are offered. They have demonstrated a determination to make the services even better in the future.

From:
Options, Challenging "Ke Garne": Experiences of the Nepal Safer Motherhood Project, Nepal Safer Motherhood Project, DFID, August 1999.

[7] The partograph is a tool promoted by WHO to monitor labor so that women who encounter problems may receive emergency obstetric care in a timely manner.

Program Recommendation #7

> *To ensure quality and adequate use of health services, dialogue with the community must be fostered. Service providers and the community should define quality together.*

Health seeking behaviors are dependent on many factors. These include social and cultural beliefs and practices and also the availability of services and the perceived quality of those services. Most health planners have tended to design health programs in the relative isolation of the medical profession and considered quality only within the biomedical paradigm instead of within the larger socio-cultural context.

The most commonly used quality-of-care framework in family planning service delivery (10) includes access, which is not limited to geographical access but also includes such considerations as cost (both the cost of services as well as opportunity costs to obtain services); service providers' respectful treatment of clients; availability of drugs and other commodities; and the technical competence of service providers. While this framework breaks new ground by considering the service providers' interpersonal relations with clients, it still fails to take into account the clients' own definition of quality, which is in part culture-based and includes traditional cultural practices as they relate to health seeking behaviors. In many instances, health planners have not given adequate attention to the clients' socio-cultural needs, and this omission has proved costly.

There are numerous examples around the world of well-equipped and well-staffed health facilities that are underutilized by the intended clients (43,54,67). In Bolivia, for example, anecdotal evidence (64) indicates that while lack of access is the main reason women don't use health facilities for childbirth, it is also true that women prefer to deliver their babies at home. Women prefer to deliver in a squatting position, but health facilities do not offer them this option. Moreover, husbands receive their child and cut the umbilical cord, but most health facilities are unable to accommodate this practice. There are also important ceremonies around the placenta, but most health facilities are unable to give the woman the placenta after the birth (54,64).[8] While some health program implementers feel that the solution to the issue of underutilized services is to market them better, others believe that strategies to engage the community in the dialogue about quality is key. A combination of both is ideal.

Engaging the community in the dialogue about quality is important because in most countries health facility service providers come from different educational and socio-economic backgrounds and do not understand the realities and needs of those in the community. Community involvement is also becoming more critical due to the increasing decentralization of health systems globally. Even in countries where the health systems have not been decentralized, however, engaging community members in the dialogue about services and

[8] The Mothercare project in Bolivia has begun to address these cultural issues in some health facilities and are making it possible for women to give birth in the squatting position and have their husbands present to receive the baby and cut the umbilical cord. The placenta is also given to the couple so that they may conduct the relevant ceremonies.

quality is likely to increase mutual understanding between the service providers and their clients, enhance service providers' respect for their clients, and increase clients' feelings of ownership, hence their use, of those services.

What this means for Networks behavior change programs

Networks will aim to empower communities and foster partnerships between the service providers and community members so that the services respond to the needs of the people who are expected to use them. One important aspect of this will be involving the community and service providers in defining quality based on the cultural model rather than relying exclusively on the biomedical definition of quality.

Some operational questions to consider

- Why do community members come to the health facility?
- Why don't others come? Is it lack of access? If so, how can the services be made more accessible?
- What mechanism(s) can be used to bring the community and the service providers together to discuss and address quality of care issues?

PARTNERSHIPS IN DEFINING QUALITY: A CASE STUDY

In rural areas of Puno, Peru, health services were underutilized because people were dissatisfied with the care they received. There is a large socioeconomic gap between service providers and clients. Many providers recognize the need for improvement in their relationships with their clients and communities, but they feel that it is the clients who need to change. Communication between providers and clients is usually vertical and often paternalistic. Clients are often afraid to ask questions and service providers do little to encourage them.

Recognizing that previous attempts to include the client's input in defining quality has resulted in treating clients as the object of the services and not as the participants, a project currently being implemented by Johns Hopkins University/Center for Communication Programs and Save the Children/US brought the service providers and community together to define quality. Together, the community and service providers identified priorities and developed strategies and action plans to improve health services and practices.

While it is still early in the project, creating a shared vision, goals, and objectives through approaches that foster equity and shared responsibility between service providers and communities has resulted in a sense of teamwork, greater accountability, and feelings of ownership.

From:
Howard-Grabman, L. Developing Accountability through Community Mobilization Approaches that Bridge the Gap Between Communities and Service Providers, Paper presented at IDS workshop, London, 1999.

NETWORKS APPROACH TO BEHAVIOR CHANGE PROGRAMS

Framework for Designing *Networks* Behavior Change Programs

The *Networks* technical approach promotes the use of three assessments to generate recommendations and strategies for designing behavior change programs (see Figure 3). The first two, which can occur concurrently and inform each other, are (1) an epidemiological assessment; and (2) a social or quality of life assessment. The epidemiological assessment will include a review of Ministry of Health (national, regional, district, and community) records to identify the most serious, frequent and preventable causes of illness and death.

A social or quality of life assessment which actively involves the community, including service providers, will obtain insights into what the community perceives as major concerns, especially those related to reproductive and child health. We recognize that there are likely to be some discrepancies between epidemiological data and quality of life data. Epidemiological data, for example, may indicate that maternal deaths are a problem, yet the social or quality of life assessment may not bring this issue to the fore. Or, conversely, the quality of life assessment may highlight social issues that are not revealed by epidemiology, such as alcoholism and domestic violence. Therefore, it will be important to work with the community and other stakeholders in partnership to discover reasons for any discrepancies and outline strategies to address health problems identified by both quality of life and epidemiological assessments.

The third assessment, done in partnership with the community and other stakeholders, targets the lifestyles and behaviors that perpetuate the health problems and identifies healthy behaviors that can lead to the prevention of these problems. During this process, barriers to the recommended health practices or behaviors and strategies for overcoming them will be identified, and appropriate behavior change program(s) will be designed.

Methodologies to be Used in Conducting the Social or Quality of Life Assessment

While the social or quality of life assessment is likely to include the methodologies described below, *Networks* will continue to look out for and make available other innovative tools and methods. A valuable resource for such tools is the CHANGE Project[9], which has compiled and continuously updates a list of tools and approaches, *Innovative Approaches and Tools for Change*. The implementing team, which will consist of staff from participating organizations in the focus country network, with support from *Networks* as needed, will decide what combination of these or other methodologies will be used in their respective programs (see Section D).

[9] The CHANGE Project is a USAID funded program that provides technical assistance in health-related behavior change interventions.

FIGURE 3 – Framework for Designing Behavior Change Programs

EPIDEMIOLOGICAL ASSESSMENT

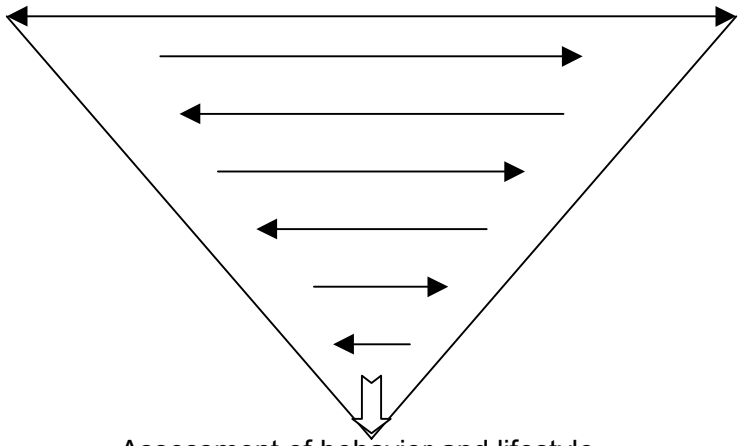
REVIEW EPIDEMIOLOGICAL DATA

- Data from MOH, Central, regional and district levels
- Health facility records

SOCIAL ASSESSMENT

ESTABLISH QUALITY OF LIFE AS IT RELATES TO HEALTH
(Community & Service Providers)

- Community Diagnosis
- RRA/PRA
- Stepping Stones methodology
- Other qualitative methodologies



Assessment of behavior and lifestyle

Assessment of barriers to behavior

- Super-structural (poverty, ethnicity, gender, traditional beliefs and practices)
- Structural (laws, policies)
- Environmental (living conditions, resources, social pressures and opportunities)
- Individual (isolation, low perception of risk)

In Partnership with Stakeholders

RECOMMENDATIONS & PROGRAM STRATEGIES

BEHAVIOR CHANGE INTERVENTIONS DESIGNED & IMPLEMENTED IN PARTNERSHIP WITH STAKEHOLDERS

Community Diagnosis

A community diagnosis involves the participation of community members and uses a variety of methodologies to obtain insights into the most common health concerns affecting a community. The community diagnosis enables the discovery of the underlying causes of health problems and explores possible solutions with community members. Activities likely to be included here are: review of MOH statistical data; focus group discussions with health providers and community members; observations of behaviors that are likely to affect health; in-depth interviews with health providers and community members; community mapping; and organizational assessments. Meetings with the community will be organized so that the results of the community diagnosis can be shared with the wider community and an agreement on priority problems for joint action can be made. Action plans will be drawn up with select members of the community such as the village health committee or a local planning group (56,66).

Participatory Rural Appraisal (PRA) or Participatory Learning and Action (PLA)

These methodologies are used in communities so that the community itself gathers and owns the data, learns from the data, and makes decisions based on what is learned. Even though this methodology uses a number of generic tools, the use of innovation and creativity to attain the needed insights is encouraged. Some popular PRA/PLA tools (13,14,17,18,19,20,31,78) to gather information on reproductive and other health issues include: participatory mapping (social, census, and body);Venn diagrams; transect walks; wealth and well-being; ranking and scoring; daily time use analysis; trend analysis; picture stories/cartooning; semi-structured interviews; focus group discussions (FGDs); case studies, stories and portraits; and role plays (Appendix D). Flexibility is the key in selecting tools, depending on the questions that need to be answered and on which tools are appropriate in a given setting. Appendix E is an example of what tools are used to answer what questions when designing an adolescent reproductive health program. Tools that are useful in planning include the problem ranking matrix, the intervention ranking matrix (for a problem), and the community action plan (Appendix D).

Stepping Stones

This methodology to build community capacity was developed specifically for HIV/AIDS (103) but has been adapted for other health and development programs. It helps individuals, their peers, and their communities to change their behavior, individually and together. The methodology (Appendix F) is based on the assumption that community-wide change is best achieved by each individual making a personal commitment to change. Consequently, participants are strongly encouraged to make a commitment to attend all the community workshop sessions.

Other Qualitative Methodologies

Other qualitative methods (88) that could be used include free listing, pile sorting, ethnographic field guides, and illness narratives (Appendix G).

How Gathering Qualitative Data Links to the Overall Monitoring and Evaluation (M&E) Plan

The *Networks* M&E strategy has a three-pronged approach to data gathering (65):

- Conducting household surveys to gather information about individual knowledge and practices.
- Conducting health facility assessments (observing services and practices; assessing health workers' knowledge, equipment, medicines, instruments, supplies, etc.; client satisfaction, which includes the use of qualitative and quantitative methodologies.
- Conducting community assessments, which use quantitative and qualitative methodologies to obtain insights into stakeholder and key informants' perceptions, priorities, needs and beliefs (Figure 4).

We envisage working closely with those implementing the M&E plan as the data, especially the qualitative data, will be used in the design of *Networks* behavior change programs (Figure 5). (For more detail, see *Networks* Monitoring and Evaluation (M&E) Plan.)

FIGURE 4 – *Networks* Monitoring and Evaluation (M&E) Strategy for Data Collection

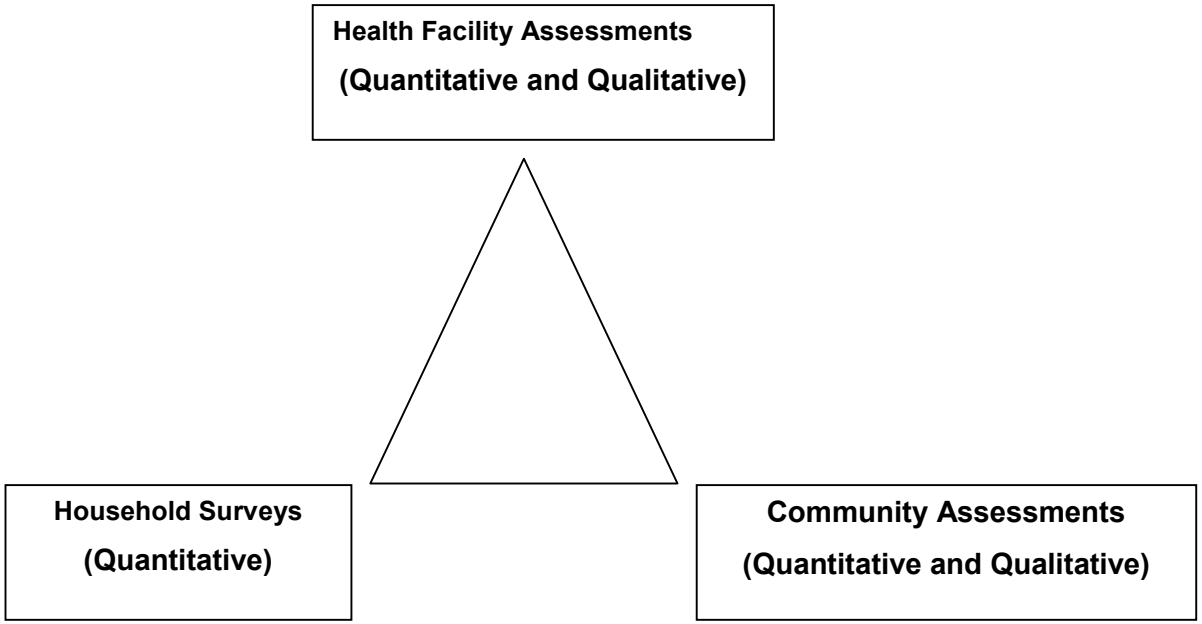
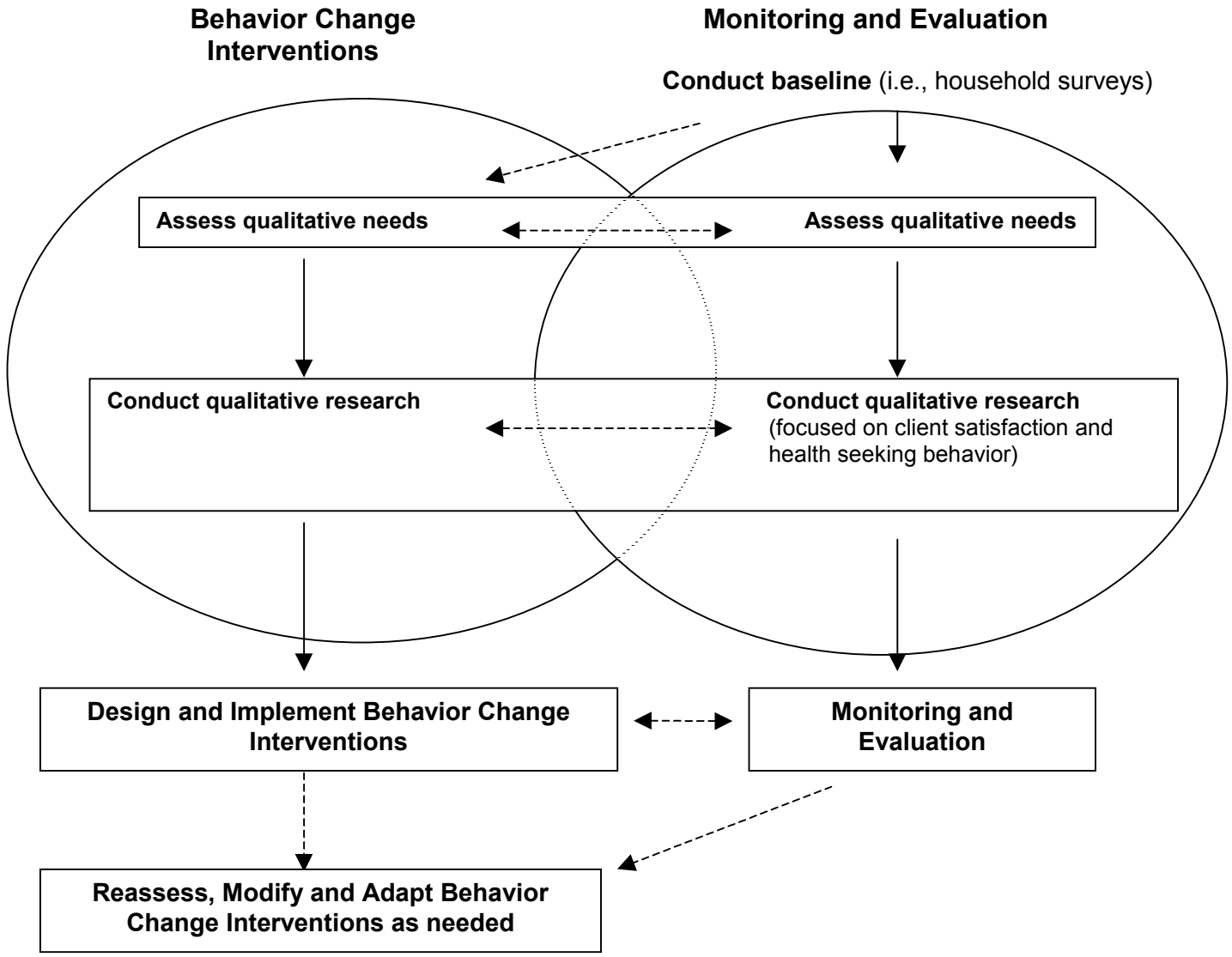

Health Facility Assessments
(Quantitative and Qualitative)
Household Surveys
(Quantitative)
Community Assessments
(Quantitative and Qualitative)

FIGURE 5 – Links Between Networks M&E Data Collection and Data Collection for the Design of Networks Behavior Change Interventions


Behavior Change Interventions
Monitoring and Evaluation
Conduct baseline (i.e., household surveys)
Assess qualitative needs
Assess qualitative needs
Conduct qualitative research
Conduct qualitative research (focused on client satisfaction and health seeking behavior)
Design and Implement Behavior Change Interventions
Monitoring and Evaluation
Reassess, Modify and Adapt Behavior Change Interventions as needed

Key Technical Approaches to be Used

The mandate of *Networks* is to expand FP/RH/CS/HIV services using new collaborative approaches, such as networks, that include partnerships between the Partners' field offices, local NGOs, local grassroots organizations, government agencies, and private sector groups. Our focus country programs can either be a national or regional program implemented in partnership with local groups or small-scale programs that are implemented by NGOs and other entities through subgrant mechanisms. In either type of program, *Networks* technical approach to behavior change programs will be community-centered, have an empowerment focus in keeping with the core values[10] of the Partners, and aim to promote social change. Although *Networks* is committed to promoting participatory processes to build self-reliance (26), we recognize that field realities may require the design and implementation of programs that use varying degrees of participation by the stakeholders (see Appendix H). Opportunities to create a multiplier effect, such as was done by TOSTAN in the movement that led to the banning of FGC in Senegal, will be explored. TOSTAN worked simultaneously with a number of communities that had marriage ties, so that when women and men in one community mobilized to ban FGC, which they felt was against their human rights; the result multiplied into a social movement. A related strategy would be to obtain the commitment of top-level political leadership, which can greatly enhance the prospects for social change. Uganda and Thailand's (93,94,95,98) response to the HIV/AIDS pandemic illustrate how top-level political commitment along with community engagement have made a difference in slowing down or reversing the spread of HIV.

Networks anticipates using a mix of technical approaches, as no one approach is appropriate for all contexts, audiences, and strategies. Given our focus on behavior change in the context of community empowerment and long-term social change (Appendix A), our preference will be for approaches that are likely to lead to social mobilization. These approaches include community mobilization, communication for social change, policy advocacy, and social marketing (15,77). We define social mobilization as a series of planned or spontaneous actions and processes that reach, involve, and influence all relevant segments and sectors of society from community to the national levels, to create an enabling environment that effects and supports positive behavior and social change (15).

Community Mobilization is a process that uses deliberate, participatory processes to involve local institutions, local leaders, community groups, and members of the community to organize for collective action towards a common purpose. Community mobilization is characterized by respect for the community and its needs.

[10] The five Partner organizations, ADRA (Adventist Development Relief Agency), CARE, PLAN International, PATH (Program for Appropriate Technology in Health), and Save the Children/US, are committed to development through community involvement.

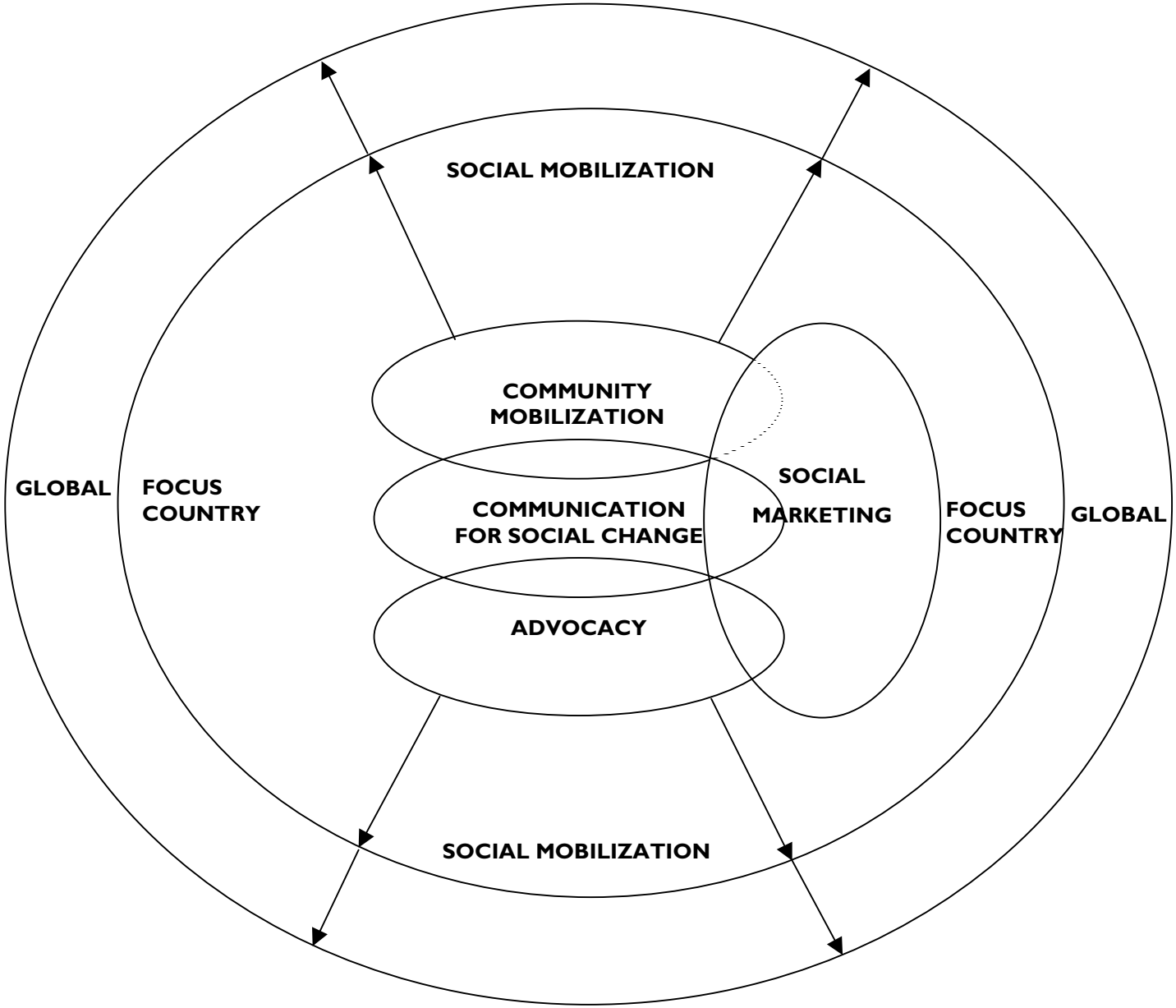
Communication for Social Change is a process of public and private dialogue through which people define who they are, what they want, and how they can get it. Social change is defined as a change in people's lives as they themselves define such change. This approach attempts to rebalance strategic approaches to communication and change by shifting the overriding emphasis:

- Away from people as the objects for change and onto people and communities as the agents of their own change.
- Away from designing, testing, and delivering messages and onto supporting dialogue and debate on the key issues of concern.
- Away from the conveying of information from technical experts and onto sensitively placing that information into the dialogue and debate.
- Away from a focus on individual behaviors and onto social norms, policies, culture, and a supportive environment.
- Away from persuading people to do something and onto negotiating the best way forward in a partnership process.
- Away from technical experts from "outside" agencies dominating and guiding the process and onto the people most affected by the issues of concern playing a central role (77).

Policy Advocacy is a process that involves a series of actions conducted by organized citizens in order to transform power relationships. The purpose of advocacy is to achieve specific policy changes or allocation of resources that benefit the population involved in this process. These changes can take place in the public or private sector. Effective advocacy is conducted according to a strategic plan and within a reasonable time frame (15).

Social Marketing promotes and sells products, ideas or services which are considered to have social value, using a variety of outlets and marketing approaches (15). Social marketing, when applied to primary health care products, such as condoms, impregnated bednets, and oral rehydration salts, is a very relevant and appropriate approach to increasing accessibility by taking distribution to scale. Some traditional social marketing has been driven by experts and has involved beneficiaries only in market research and pre-testing of messages. Other programs have made a concerted effort to involve stakeholders more actively in the design, implementation, and evaluation of the process (16). *Networks* will embrace the latter approach. In addition, we will look for opportunities to do community-based social marketing, which is a minimalist form of social marketing adapted for use by those who are not advertising and other professionals (21).

FIGURE 6 - Behavior Change Intervention Technical Approaches to be Used in *Networks* Programming


SOCIAL MOBILIZATION
COMMUNITY MOBILIZATION
GLOBAL
FOCUS COUNTRY
COMMUNICATION FOR SOCIAL CHANGE
SOCIAL MARKETING
FOCUS COUNTRY
GLOBAL
ADVOCACY
SOCIAL MOBILIZATION

Communication Channels and Strategies to be Used

The effective use of communication channels and strategies is central to all behavior change technical approaches. Given *Networks* commitment to community empowerment, we will select communication channels and strategies that promote critical thinking by engaging people in dialogue. While interpersonal communication is a key channel, others will be used in complementary and mutually reinforcing ways. These include counseling, print, popular media, mass media, and a combination of mass communication or popular media with interpersonal communication.

Interpersonal communication is the face-to-face, verbal and nonverbal exchange of information or feelings between two or more people and is a key channel in most of the technical approaches *Networks* will use in behavior change programming—especially community mobilization and communication for social change. Peer education and child-to-child programs are examples of specific strategies that use interpersonal communication.

Counseling is defined as a process in which the counselor or service provider assists the client to explore his/her feelings and to make informed decisions about the best course of action(s) to pursue. It is a process that recognizes two experts: the service provider who has the technical information and the client who knows what is best for him/herself. Yet service providers for the most part have been trained to give people technical information by rote without having been given adequate skills in understanding the clients' personal circumstances and facilitating the clients' exploration of their own options. *Networks* will approach counseling from a systemic point of view and encourage the client to explore his or her options, identify solutions for him/herself, and outline a plan of action when feasible. However, recognizing the constraints faced by providers, such as inadequate time with each client and the lack of privacy in most health facilities, we will also, explore strategies to empower providers themselves so that they may seek innovative, realistic solutions to the constraints on providing comprehensive and systemic counseling to their clients.

Print is a very important medium, especially for disseminating accurate health information, including instructions on how to use a health product or how to recognize danger signs in a particular situation. Literacy, however, constitutes a challenge to the use of print. As literacy levels are likely to be low in most of the countries where *Networks* will work, we will facilitate the development of simple, pictorial materials for low and illiterate audiences (105) as needed and train service providers and others in their use. In addition, we will look for opportunities to incorporate basic human and reproductive health rights, family planning, other reproductive health, and child survival information into literacy and other skill-building programs.

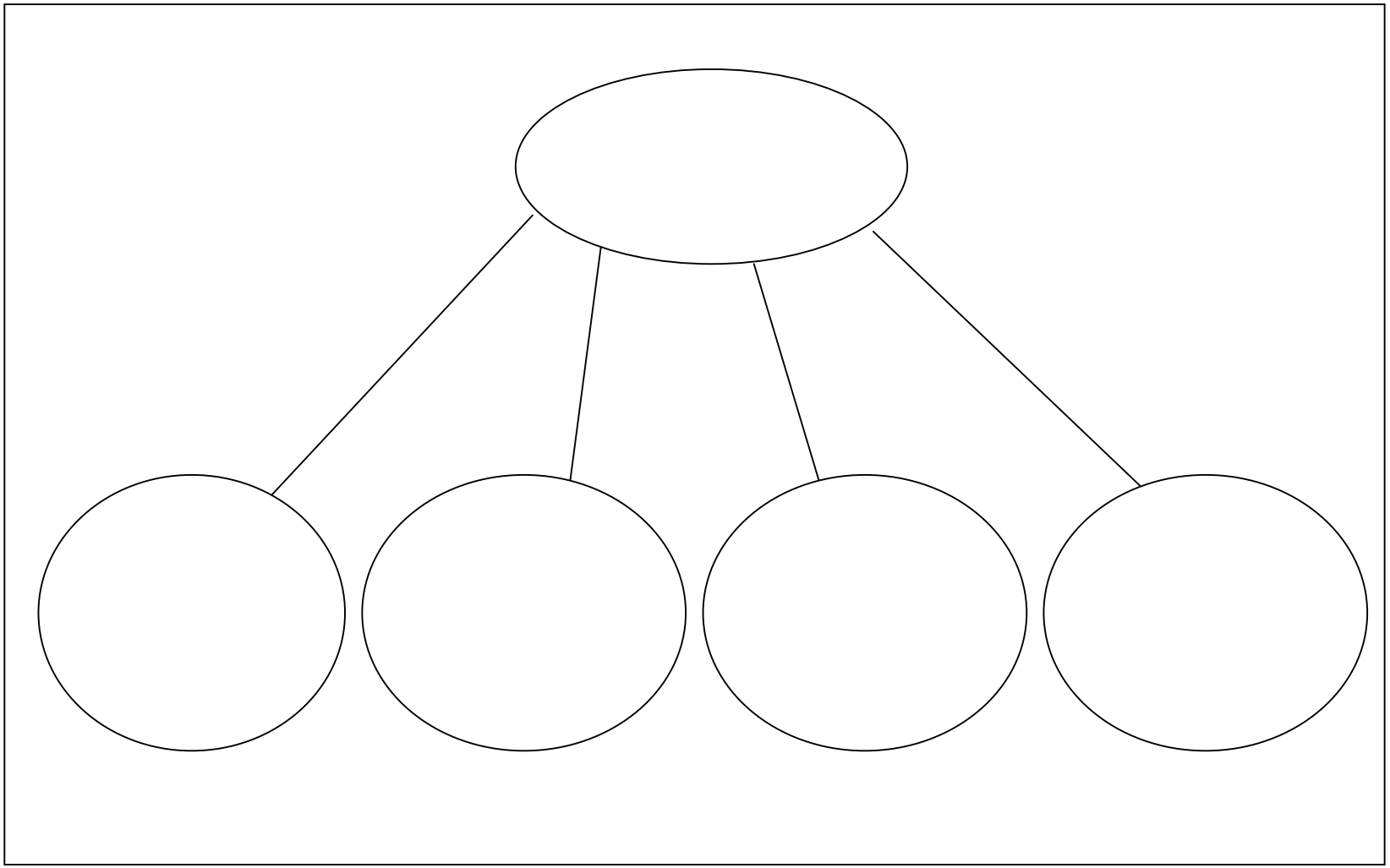
Popular media such as community theater, puppet shows, songs, dances, poems, and story telling have played an important role in passing on history, sharing information, and providing entertainment within all cultures. We will identify and use appropriate popular media to promote dialogue and critical thinking about family planning, and other reproductive health and child survival issues.

Electronic and other types of mass media are effective media for disseminating information to large numbers of people, as radio and TV are becoming more accessible even among the lower income groups throughout the world. A particular challenge will be how to include those who previously were not included in the dialogue, especially the marginalized, as this channel of communication has been controlled predominantly by the elite and others with power. We will therefore explore ways of increasing the community's ownership of these channels so that more people can be involved in the dialogue. Key media we will use wherever feasible are community radio and video, especially in community mobilization activities.

The combination of mass media or popular media with interpersonal communication is an effective strategy to promote critical thinking and dialogue. We will use mass or popular media to spark critical thinking and dialogue about the particular health issue and the interpersonal communication to keep the dialogue alive. Some examples of combinations are facilitated radio listening groups and discussions after community theater performances or dances.

There are exciting examples of how clients have been empowered to demand better treatment from service providers as a result of mass communication. In Nepal, for example, due to terrain which makes getting around the country difficult, distance education and training programs in interpersonal communication and counseling were conducted by radio. Since clients were also able to tune in to these training programs, they were able to learn the principles of interpersonal communication and counseling and to understand what they should expect from service providers (66).

Figure 7 - Communication Strategies and Channels



IMPLEMENTATION STRATEGY

The Entry Plan

This section presents a general plan for designing and implementing behavior change program activities in the *Networks* focus countries. However, because each country will present different challenges, the behavior change program plan will be flexible so that it can be adapted as needed to the country circumstances.

Step 1: *Networks* would first learn how the NGO Partners in the focus country design and implement behavior change programs at the country level. To this end, *Networks* will develop an inventory of such things as:

- *Current approach to behavior change programs*:
  - What are their guiding principles to behavior change programming?
  - How are behavior change programs designed and implemented? Are the programs determined by the personality of the person(s) designing and implementing them?

- *Current human resources available for designing and implementing behavior change programs:*
  - Who designs and implements behavior change programs? Is there a designated person for this or does a program person incorporate behavior change into broader reproductive health programs? What is their training?
  - How many people are involved in the design and implementation of behavior change programs?

- *Development and dissemination or use of communication materials and other interventions:*
  - How are communication materials developed? What are the other interventions that have been developed? Are they developed internally or contracted out?
  - What processes are used?
  - Who is in charge of materials development? What skills does this person(s) have?
  - How are communication materials disseminated? How are the other communication interventions used? What training is associated with the dissemination and use of communication materials and interventions?
  - What storage facilities to store print and other communication materials exist?

See Appendix H for more detailed information of the inventory.

Step 2: *Networks* will then learn how the other focus country networks organizations approach behavior change programs.

Step 3: The *Networks* Behavior Change Communications Advisor will coordinate a meeting of key people from the NGO Partner and other focus country networks organizations to: (1) learn about each other's successes and resources in behavior change programming; (2) critically review the *Networks* Behavior Change Intervention Technical Approach; (3) outline a common

approach that draws from all available resources for designing and implementing behavior change programs and programs that are appropriate to the local context; (4) outline individual implementation plans (including the strategies, qualitative methodologies, and interventions to be used); (5) identify capacity-building needs and outline the requisite technical assistance needs; (6) review existing communication materials and programs to identify information gaps and alternative or additional channels or media to disseminate information; and (7) outline strategies to address these information and communication channels/media gaps.

A key focus of this meeting will be to raise the participants' consciousness to the potential and the comparative advantage of working as part of a network. Strategic partnerships will be encouraged so that organizations with complementary strengths will work together. In this way organizations can stay focused on building their capacity in the specific areas that they have undertaken and not try to be all things to all people. For example, if an organization has as its mandate the delivery of clinical services, it would focus on building its capacity in this area, but it would not try to engage in community mobilization to increase the use of services. Instead, it would partner with other organizations working in the same geographical area that specialize in community mobilization.

Step 4: The focus country networks staff, with assistance from the *Networks* Behavior Change Communications Advisor, will provide systematic support to the focus country NGO Partners and others in expanding further their respective behavior change strategies and implementation and capacity building plans.

Step 5: The focus country networks staff and the *Networks* Behavior Change Communications Advisor will look at the nuts and bolts of how the qualitative research will be conducted and the programs will be implemented. Detailed timelines will be developed. Needed resources will be identified and allocated. Links to the overall M&E plan will identified so that qualitative research can be conducted in a coordinated manner without duplication of effort.

Step 6: The *Networks* Behavior Change Communications Advisor will work closely with the focus country networks staff to identify the technical assistance needs and outline a capacity-building plan which complements the *Networks* global and the specific focus country capacity-building plans.

Step 7: The focus country networks staff and the *Networks* Behavior Change Communications Advisor will periodically update the local USAID mission regarding how the local *Networks* approach to behavior change is evolving.

Step 8: Sponsor a number of ongoing support activities, such as compiling and disseminating generic tools and guides, establishing forums for discussion and sharing information, and helping focus country staff identify and meet their needs for technical assistance.

Country-Specific Behavior Change Intervention Strategies

The focus country network staff, with support from the *Networks* Behavior Change Communications Advisor, will design and implement country-specific behavior change program strategies. Their tasks will include:

- Designing program goals and objectives
- Designing program strategies
- Developing a monitoring and evaluation plan
- Identifying needs for technical assistance and how to meet them
- Creating a communication plan
- Creating an advocacy plan
- Creating a training plan
- Identifying roles and responsibilities of key players
- Conducting an inventory of local resources
- Deciding how resources will be mobilized

See Appendix I.

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APPENDIX A — Glossary

Appreciative Inquiry is a methodology that focuses on the capacities, assets and resources of a community instead of the needs, deficiencies, and problems. A thorough map of the assets would begin with an inventory of the gifts, skills and capacities of the community's residents. The basic truth about the "giftedness" of every individual is particularly important to apply to persons who often find themselves marginalized by communities.

Community can be a group of people who live in a defined territory as well as groups of people who may be physically separated but who are connected by profession, interests, age, ethnic origin, language, or other characteristics.

Community capacity is recognized to be a necessary condition for the development, implementation, and maintenance of effective, community-based health promotion and disease prevention programs. It includes the following dimensions: community power, participation and leadership, skills, resources, social and interorganizational networks, sense of community, understanding of community history, community power, community values, and critical reflection.

Community empowerment is the process by which groups of individuals, organizations and communities are enabled to share "power" to collectively analyze problems, propose solutions, mobilize and manage resources, and act effectively to positively transform their lives and their environments.

Community mobilization as a process uses deliberate, participatory processes to involve local institutions, local leaders, community groups, and members of the community to organize for collective action towards a common purpose. Community mobilization is characterized by respect for the community and its needs.

Community organization is a process (of change) that empowers people in terms of their acquiring skills, knowledge, experience, supportive relationships, and individual and collective efficacy needed to identify assets, strengths, resources, problems, and needs, and to assume responsibility to develop, plan, manage, control, and assess the collective actions necessary to promote the welfare and development of their communities. This process entails actions taken within a community as well as collaboration and links with others outside of the community.

Community participation is a continuum of degrees to which individuals and groups are involved in participation, ranging from the lowest, most passive level of participation to the highest, most active. Elements of participation concern:

- WHO is participating;
- WHO IS NOT participating;
- HOW they are participating;
- HOW MUCH they are participating;

- WHAT KIND of participation (e.g., the type of participation); and
- WHY they are participating.

Participation includes both individuals and groups. There can be negative sides to participation; its benefits/advantages depend on the process in which it occurs. Community participation is operationalized through the process of community mobilization.

Critical thinking is the process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action.

Empowerment is a process through which individuals, as well as local groups and communities, identify and shape their lives and the kind of society in which they live. Empowerment can be experienced on an individual level or in terms of the household, local groups, community or a larger entity. Empowerment means that people are able to organize and influence change on the basis of their access to knowledge, to political processes and to financial, social, and natural resources.

Enabling environment is one in which all the factors (e.g., government policies, communities engaged, accessible roads, and so on) on which the successful outcome of a program or project are dependent are in place.

Self-efficacy is the degree of confidence a person has about being able to perform a specific task or behavior. Self-efficacy has both cognitive and behavioral dimensions. For example, general attitudes about self are likely to influence one's sense of efficacy about a task or behavior that is difficult to perform; at the same time, self-efficacy may be increased through practicing a task or behavior or by watching others similar to someone perform the task or behavior.

Social change is defined as change in people's lives as they themselves define such change. Many in the development community are committed to social change that will result in improving the lives of the politically and economically marginalized, and change which is informed by principles of tolerance, self-determination, equity, social justice, and active participation by all.

Social mobilization is a series of planned or spontaneous actions and processes that reach, involve, and influence all relevant segments and sectors of society from community to the national levels to create an enabling environment that effects and supports positive behavior and social change.

APPENDIX B — An Illustrative List of Program Indicators Related to Actions and Behaviors Promoted by the Project

1) Contraceptive Prevalence Rate (CPR) (or percentage of women 15-49 currently using contraception by method) (stratified by new/old acceptors, and 0, 1, 2 parity)

2) Percentage of most recent birth spaced more than 23 months and less than 35 months among women with children 0-11 mo.

3) Percentage of obstetric complications transferred from the community to the next higher level of care divided (assume that 15% of expected births are complications)

4) Percentage of women with children 0-11 months whose most recent birth was unintended

5) Percentage of births of women with children 0-11 months attended by appropriately/medically trained health personnel

6) Percentage of women <24 years of age who had a first birth before the age of 20 years

7) Percentage of women with children 0-5 months consciously & correctly using LAM as a FP method

8) Average age of onset of first sexual intercourse

9) Percentage of children 0-23 months who have had diarrhea in the past two weeks who received Oral Rehydration Solution (ORS) (as per the definition used by the national diarrhea disease control program) or a recommended home fluid (case stratified)

10) Percentage of children 0-23 months who have had diarrhea in the past two weeks who received the same amount or more food (case stratified)

11) Percentage of infants 0-11 months who were put to the breast within 1 hr after birth (and by interval of time after birth)

12) Percentage of infants 0-5 months exclusively breastfed (using recall of mothers with children 0-5 months)

13) Percentage of infants 6-9 months who were given breast milk and solid foods (using 24 hour maternal recall)

14) Percentage of women 15-49 years who used a condom in their last sexual contact

15) Percentage of men 15-49 years who used a condom in their last sexual contact

16) Percentage of adults 15-49 who correctly insert condoms on a condom model

17) Percentage of health workers working in health facilities who deliver services per the standards of the health facility assessment/situation analysis instrument/other relevant instruments

18) Percentage of women/men in exit interviews satisfied with most recent service delivery at the health facility

19) Percentage of mothers with infants 0-5 months who attended antenatal visits by a clinically trained

APPENDIX C — Theories of Behavior Change

While NGO Networks for Health will consider individual behavior change theories such as those described in the sections on Stage/Step Theories and Cognitive Theories, our focus will be on social change theories. Some key social theories are discussed below, but we anticipate identifying and using other social theories as they come to the fore.

Stage/Step Theories

Input/output Persuasion Model
It emphasizes the hierarchy of communication effects and considers how various aspects of communication, such as message design, source, and channel, as well as audience characteristics, influence the behavioral outcome of communication.

Stages of Change Theory
This theory identifies the stages a person goes through as they adopt new behaviors. Changes in behavior result when the psyche moves through several iterations of spiral process; from precontemplation through contemplation, preparation, and action, to maintenance of the new behavior.

Health Belief Model
This psychological model attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals.

Cognitive Theories

Theory of Reasoned Action
This theory specifies that adoption of a behavior is a function of intent, which is determined by a person's attitude (beliefs and expected values) towards performing the behavior and by perceived social norms (importance and perception of others).

Social Cognitive (Learning) Theory
The theory states that a person's behavior and cognition affect future behavior. Human behavior according to this model is explained in a triadic, dynamic, and reciprocal model in which behavior, personal factors, and environmental influences all interact. An individual's behavior is uniquely determined by these interactions. Among the crucial personal factors are the individual's capabilities to symbolize behavior, to anticipate the outcomes of behavior, to learn by observing others, to have confidence in performing the behavior (including overcoming any barriers to performing the behavior), to self determine or self regulate behavior, and to reflect and analyze experience.

Social Change Theories

Diffusion of Innovations Theory
It examines how new ideas, products, and social practices spread from person to person and from one community or society to another. Diffusion is not seen as a one-way process, but a more complex interaction within networks of media, social groupings, and opinion patterns. This model describes the factors that influence people's thoughts and actions, and the process of adopting a new technology or idea.

Social Change Theories
The recognition that local values, norms, and social behavior patterns affect individual behavior has meant an increasing focus on the community as a means of achieving permanent, large-scale behavior change. Proponents of this "community" approach strive to change the standards of acceptable behavior in the community; that is, by changing community norms about health-related behaviors.

Social Network Theory
Theories of behavior change which emphasize the power of social networks identify two basic sources of influence. One of these can be called "normative influence." It is motivated by a person's simple wish to gain a group's approval. "Informative influence" is motivated by a belief that the group's consensus, although in conflict with one's own attitudes or behaviors, must be objectively correct.

From:
Strand, J. Summary of Change Theories, Compilation for the National Cancer Institute's Office of Cancer Communications, 1994.
Horizons Project, Behavior Change Intervention Strategy, 1998.

APPENDIX D — Some Popular Participatory Rural Appraisal (PRA)/Participatory Learning and Action (PLA) Tools Used in Reproductive Health Programming

Tool:	What it is:
Social Maps	Community members draw a visual presentation of their residential area to show settlement boundaries, the social infrastructure (roads, water supply, schools, playgrounds, places of workshop, clinics, and other public spaces) and the housing pattern—with all the houses in the area shown in the map.
Census Mapping	Census mapping is used to put together easily quantifiable information about the settlement, e.g., household information, like number of adults (men and women), number of children (boys and girls), education and literacy, employment, resource ownership, health problems (e.g., incidence of malaria or tuberculosis), use of contraceptives, etc. It is done by household.
Transect Walks	A transect walk takes the team on a mobile interview where team members walk through the community with "guides" from the community. As they go, they ask questions related to the things they see, as well as other issues from their prepared checklist.
Wealth and well-being ranking	This is a ranking technique in which the community itself ranks families in terms of their relative wealth.
Body maps	Participants draw diagrams that depict their understanding of how the human body is structured and how the organs function and relate to one another.
Venn diagrams	A Venn diagram offers another way to "map" a community, but this one focuses on social relationships rather than physical ones.
Ranking and scoring	Ranking is a method whereby the options are evaluated and ranked in a sequence. It is used to analyze preferences, prevalence, and decision-making processes. It helps in analyzing the different options available or considered under one subject, the criteria or the basis of which these are evaluated by the individual or group, how each of these options fares against the selected criteria, and the final choice of the participants.
Causal-impact analysis (flow diagram)	Flow diagrams are diagrams that are drawn by the participants so that the causes and impact of an event, problem or activity on people's lives can be understood. These diagrams also help in identifying links between different causes and impact.
Daily time use analysis	This is a method that gets participants to list sequentially all the activities that they engage in during a typical day. Although it is more effectively done with individuals, it can also be used in groups.

Seasonality analysis	Participants develop a calendar in which they divide the year by months, seasons, or quarters, to list activities, events, or problems. This enables an analysis of cyclical patterns that include the availability of food, prevalence of diseases, indebtedness, relative prosperity, stress in livelihoods, levels of sexual activity, availability of free or leisure time and so on.
Trend analysis	This method is used to understand people's perceptions and patterns of change, usually within a 40- to 50-year period, regarding selected indicators and topics that are of concern to them. This is a useful tool to initiate a discussion with older people to analyze their perceptions of changes taking place in their community and in their own lives.
Picture stories/cartooning	This is a simple technique, where the participants are asked to prepare, individually or in a group, a pictorial presentation of sequence of events that are likely to take place in a person's life. It is used to get a more in-depth understanding of sexual behavior and to triangulate the results obtained on the subject from other discussions.
Semi-structured interview (SSI)	Semi-structured interviews (SSI) are guided conversations in which only the topics are predetermined and new questions or insights arise as a result of the discussion and visualized analysis.
Focus group discussions (FGDs)	Focus group discussions are small group meetings for discussing a specific topic, which is led by a discussion leader who uses a topic guide. These are conducted in an informal setting where all the participants are encouraged to present their views and opinions.
Case studies, stories and portraits	This method involves the reporting of anecdotes, individual life histories or the description of a significant event in a person's life, which comes up during discussions as they provide valuable insights on the issues being discussed.
Role-plays	Role-play is an enacted presentation of a real life situation. Participants can present their own experiences or those they have heard or seen. Role-plays can vary from very short sketches, which present an event or a character, to longer ones which may cover several aspects of a theme.

CARE. *Embracing Participation in Development: Worldwide experience from CARE's Reproductive Health Programs with a step-by-step field guide to participatory tools and techniques*, October 1999.
Schoonmaker Freudenberger, K. *Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A Manual for CRS Field Workers and Partners*, Catholic Relief Services, 1998.
The Johns Hopkins University School of Public Health. Training in Qualitative Research Methods for PVOs and NGOs (and counterparts), August 1999.

APPENDIX E — Illustrative Checklist of Issues and Methods for use in Participatory Assessments on Sexual and Reproductive Health with Adolescents

ILLUSTRATIVE ISSUES	TOOLS AND ACTIVITIES FOR SHARED LEARNING																
	Social Maps	Census Mapping	Transect Walks	Wealth & Well-being Ranking	Body Maps	Venn Diagrams	Listing, Ranking & Scoring	Causal Impact Analysis (Flow Diagrams)	Daily Time Use Analysis	Seasonality Analysis	Trend Analysis	Participatory Sex Census	Picture Stories/Cartooning	Semi-structured Interviews	Focus Group Discussions	Case studies, mini-life and portraits	Role-plays
Information/Knowledge																	
From what sources do adolescents get information on sex, reproductive health and contraceptives?						X	X					X	X	X	X	X	X
Type of knowledge they possess and depth of information about: reproductive health system, pregnancy, contraceptives, STIs, treatment of STIs					X		X	X		X			X	X	X	X	X
Needs expressed for other information					X	X	X									X	
With whom do they feel free to discuss their health problems and fears?						X	X					X	X	X	X	X	X
Attitudes																	
What is the ideal age to get married?					X		X	X			X		X	X	X		
What is the ideal age to have children?					X		X	X			X		X	X	X		
Views on use of contraceptives					X		X	X			X		X	X	X		
Conditions under which contraceptives are used							X	X					X		X		
Conditions under which contraceptives are not used							X	X							X		
Do girls or boys carry more STIs?							X	X			X	X			X		
In case of pregnancy, who takes responsibility?							X	X			X	X	X	X	X		
Is it acceptable to have sex with a close relative (which relatives and why)?						X	X					X	X	X	X		
Why sex?							X	X			X	X	X	X	X	X	X
Why no sex?							X	X			X	X	X	X	X	X	X
Proportion of girls and boys abstaining from sex							X					X					
Behavior																	
Age at first sex					X		X				X	X	X	X	X	X	X
Gap between first and second sex							X					X	X	X	X		
Number of partners and reasons				X			X	X	X			X	X	X	X	X	X
Payment for sex - what and how much?							X	X	X			X	X	X	X	X	X
Preferences for sex partners: type, age, wealth/well-being, relationship		X		X			X	X				X		X	X		X
In which places do adolescents have sex?	X		X				X						X		X		
What do they do when they have STIs?								X					X	X	X	X	
What do they do when they become pregnant or make a girl pregnant?								X					X	X	X	X	X
Proportion of girls becoming pregnant							X	X			X	X	X		X		
Proportion of pregnancies ending in abortion (with reasons for the same)							X	X			X	X	X		X		
Who decides whether/type of contraception to be used?							X	X					X	X	X	X	X
Who obtains contraceptives?							X	X					X	X	X	X	X
Preferences for different types of contraceptives							X	X							X		
Use of condoms, proportion of couples using condoms							X								X		
Where do they get the condoms?	X		X				X						X	X	X		
Are the condoms easily available?															X		
What are the constraints to increasing the adoption of condom use?							X	X					X		X		
Impact of adolescent sexual activity							X	X					X		X	X	X
Living Conditions and Sexual Relations																	
Distribution according to living arrangements (who do they live with)?	X	X	X				X		X								
Most preferred living arrangement							X										
Relation between level of sexual activity and living arrangement				X			X	X	X			X	X		X	X	X
Frequency of sexual relations with close relatives				X		X	X		X			X		X	X		
Circumstances under which this sexual activity takes place (forced or voluntary)				X		X	X	X			X	X	X	X	X	X	X
Trends																	
Cross-generational changes with respect to: age of sexual initiation, levels of sexual activity, sources of information, traditions/beliefs, methods of family planning, number of sexual parterns, practice of safe sex, types and treatment of STIs							X			X	X				X		
The Use of the Clinic																	
Proportion of adolescents using the clinic	X	X				X	X	X		X	X				X		X
Reasons for which the adolescents use the clinic							X	X							X		
Can the utilization of the clinic facilities be increased - how?							X	X							X		
Information on whether any services are provided free of charge at the clinic															X		
Adolescents' Suggestions																	
Regarding improving the clinic services							X	X							X		
Regarding improving their reproductive and sexual health					X		X	X							X		

Source: Shah, 1999

APPENDIX F — The Stepping Stones Approach

The goal of *Stepping Stones* is to enable women and men to describe and analyze their experiences and to develop their own solutions to the sexual health dilemmas they face. It aims to illuminate the effects of gender roles and address the vulnerability of women and young people in decision-making about sexual behavior. *Stepping Stones* is based on the following principles:

- The best prevention strategies are those developed by community members themselves.
- Different peer groups need their own time and space to identify and explore their own needs.
- Behavior change will be more effective and sustained when all members of the community are involved.

It was developed as a training package for HIV prevention programs, but it is a methodology that has been locally adapted to help communities address family planning issues, domestic violence, STIs, and other locally defined gender issues. Central to the training workshops are the following four themes:

- **Group cooperation skills**: including ground rules, risks, our bodies, our sexual health, gender roles, and concerns about judging ourselves and others.
- **Information on HIV/AIDS:** including transmission, protection, condoms, and the like.
- **Why we behave in the ways we do:** gender roles, alcohol, traditions, money and power.
- **Ways in which we can change:** assertiveness, "I" statements, trust, coping with death and planning for the future.

The original training package consists of a manual and a video, which describe how to run 18 workshops sessions over several weeks. The approach is participatory and involves working with four different peer groups based on age and gender. All of the work in the peer groups is based on the participants' own experiences. A facilitator leads them through exercises to understand themselves and their situations better. No reading or writing skills are needed. All of the exercises in the manual are based on drawing exercises and role-plays that enable people to "rehearse for reality." Through building on participants' own acting, drawing, singing, and dancing skills, everyone can take part on an equal level. It is important to remember that these workshops are only the very beginning of a process, not an end in themselves.

APPENDIX G — Other Qualitative Methods that could be used in Designing *Networks* Behavior Change Interventions

Participant Observation. The main purpose of this methodology is to explore issues, thoughts, and questions and to build rapport with those being observed. When using this methodology, one alternates between participant and observer and does not visibly take notes.

Unstructured Focus Observation. This type of observation is done in an obvious way as the observer openly records the data, including verbal and nonverbal behaviors. The observer can use a guide or a checklist when conducting the unstructured focus observation.

Free Listing. This methodology uses at least 10 informants and gets them to answer a primary question such as, "What are all the different kinds of X that you can think of?" or "Name all the Xs you know." Secondary questions are optional but may include ones for the purpose of clarification or additional information. Examples of these include, "Describe what happens when X occurs" or "What should a person do if X occurs?"

Pile Sorting. This methodology can provide insight into how informants group things on the basis of their cultural classification system.

Ethnographic Field Guides. This methodology enables the researcher to identify and explore relevant topics with key informant using 10-20 questions, which act more as guides rather than a survey instrument.

Illness Narratives. This methodology enables the researcher to identify how things actually happen in real settings vs. hypothetical situations and enables the researcher to triangulate information gained with other tools. For example, in a childhood illness narrative, one would: elicit a story of events surrounding a recent childhood illness of interest; and identify illness terms, causes, home treatments used, dietary changes during illness, providers used to treat illness, and cost issues.

These findings can then be used to design the communication strategy.

From:
The Johns Hopkins University School of Public Health. Training in Qualitative Research Methods for PVOs and NGOs (and counterparts), August 1999.

APPENDIX H — Participation Continuum: Means and Ends

Mode of Participation	Type of Participation	Outside Control		Potential for Sustainability, local action & ownership
Co-opted	• Tokenism, manipulation • Reps are chosen but have no real power or input	********** ********** **********	ON/FOR	
Cooperating	• Tasks are assigned, with incentives, outsiders decide agenda and direct the process	********** ********** **********	FOR	
Consulted	• Local options are asked for • Outsiders analyze and decide on course of action	********** ********** **********	FOR/WITH	* ** ***
Collaborating	• Local people work together with outsiders to determine priorities; responsibility remains with outsiders durecting the process	********* ******** ******* *****	WITH/BY	***** ****** ******* ********
Co-learning	• Local people and outsiders share their knowledge to create new understanding and work together to form action plans with outsider facilitation	**** *** ** *	BY	********** ********** **********
Collective Action	• Local people set their own agenda and mobilize to carry it out using outsiders not as initiators/facilitators but as required by local people			********** ********** ********** **********

Adapted from: Andrea Cornwall, 1995

APPENDIX I — Illustrative Checklist of Questions to Consider when Developing a *Networks* Focus Country Behavior Change Program Strategy

Steps:	Key Questions to Address:
1) Determine goals (and objectives) of the *Networks* focus country program:	• What are the program goals (and objectives)? • Who defines them? • How will they be defined? Can we begin by outlining the main goal alone, e.g., reducing maternal and neonatal mortality, and then determine the specific objectives in partnership with the stakeholders, including the community? If not, how will we involve the stakeholders in the design of the interventions? How will we foster ownership?
2) Identify overall reproductive health program strategies to be used:	• What are the key program strategies to be used? (Examples of program strategies include: 100% condom policy in brothels; condom plus another method; etc.) • What are the specific elements of the key program strategies? • Is building partnerships and/or coalitions one of them? If so, who are the potential partners? (see Step #3) • What are the steps and tools that will be taken to build the partnership or coalition?
3) Identify current efforts in behavior change programs and how the *Networks* approach will fit in:	• What other organizations or groups are doing similar work in the areas we propose to work in? • What is their technical approach to behavior change intervention(s)? • How would the *Networks* approach fit in with what is currently being implemented? Will *Networks* complement or replicate current efforts? If the proposed *Networks* approach is likely to replicate current efforts, how can we work together to maximize resources? • How are these groups currently working together? How will *Networks* work with these groups? • What are the available technical resources within the groups that are working on behavior change intervention(s)? How can *Networks* leverage or build on these resources?
4) Determine the capacity building needs of the Partners and others working together to form a network in the focus country:	• What behavior change programs have been designed and implemented by the Partner organizations and others involved in the focus country networks? • What have been their guiding principles in implementing behavior change programs? • What communication programs have they implemented? That is, what specific communication materials, programs, etc. have they developed? • What behavior change program/communication technical skills do the Partners and others who are involved have? • How will their buy-in and ownership of the *Networks* approach to behavior change programming be fostered and supported?

Steps:	Key Questions to Address:
	• What are the behavior change program/communication technical skills needed within the Partner organizations and other groups involved in the focus country networks to design and implement effective behavior change program(s)? • Who will outline the capacity building plan? How will this plan be implemented? What resources are needed? How will these resources be accessed? (see Step #6) • How will the Partner organizations and others who are working together to form a network going to work together in the focus country (at the district, provincial, and the national levels) and how will they approach behavior change program(s)?
5) Design and implement behavior change programs:	<u>Overall:</u> • How will the behavior change program(s) be designed and implemented? What organizations or groups will form the network? Are there any additional groups or organizations involved in the behavior change programs who are not in the overall focus country network? What will their role be? • How will these organizations be brought together to promote capacity building, trust, and collective efficacy? • Who will have overarching responsibility for the design and implementation of the behavior change program(s)? How will this decision be made? • Who are the key stakeholders in the behavior change program(s)? How will they be involved in the design and implementation of the behavior change program(s) and how will their buy-in and ownership of the program(s) be fostered and supported? • What is the potential for strategically including several communities with links to create a multiplier effect? What can be used as a catalyst to foster collective action? • What are the behavior change goals? How do these relate to the program goals? Can these be determined in partnership with the stakeholders, including the community? If not, how do we foster buy-in and ownership? • If so, what qualitative research and action methodologies will be used? What tools will be used? Who will determine what methodologies and tools to use? • How will this data collection be linked to the *Networks* Monitoring and Evaluation Plan? • What are the behavior change program strategies to be used? Who will determine these strategies? What technical approaches do these strategies reflect? • What are the resources that will be needed? How will these resources be mobilized? (This will need to be determined after the communication, training, and monitoring and evaluation components have been outlined.)

Steps:	Key Questions to Address:
	Communication Plan: • What communication channels and strategies will be used at each of the levels: individual; household; community; health facility; regional; and national? How will the decisions about what channels and strategies are to be used be made? What tools will be used to assess most effective communication channels and strategies? • How will the communication materials and interventions (by audience and level) be developed? Will it be done in-house or will it be contracted out? What are the skills needed? Do these skills exist within the organizations implementing this program? If not, how will this shortage of skills be addressed? (see Step #4) • What will the approach to developing the content of these materials be? How will the stakeholders, especially the community, be involved and at what stage? • How can we foster true participation and dialogue among the stakeholders, especially the community, in the development and use of the communication materials and other interventions? What specific strategies will be used to foster social change? • What are the storage facilities for communication materials? Are they adequate? If inadequate, how will this be addressed? • What are the specific strategies for launching or disseminating these materials? What will the timeline for the launch and dissemination be? • What are the specific training needs as they relate to the entire communication plan? (see training plan) • Who is responsible for implementing the communication plan? • What are all the resources needed to design and implement this communication plan? • What resources exist within the participating organizations and groups to design and implement an effective communication plan? How can these resources be mobilized? Advocacy Plan: • Who are the key stakeholders? • What are the key issues? • What are the main barriers? • Who are your adversaries, i.e., who are the ones who disagree with your point of view? Who are your friends, i.e., who are those that share your point of view? • What is the approach forward? • What are the indicators of success?

Steps:	Key Questions to Address:
	• What is your timeline? • What will be the impact on the bigger environment or issue? <u>Training Plan:</u> • What are the training needs: - interpersonal communication and counseling; - materials development; - how to contract out to advertising agencies; - program planning; - program management; - monitoring and evaluation? • Who needs to be trained? Who will do the needs assessment? How will it be done? • How will they be trained, e.g., training-of-trainers model? By whom? • What methodologies will be used? What curricula will be used? Do curricula need to be developed or adapted? If so, who will develop or adapt them? • Who will be responsible for the implementation of the training plan? • What are the resources needed in designing and implementing the training plan? • What resources in all aspects of training exist within the participating organizations? How can these resources be mobilized? <u>Monitoring and Evaluation Plan:</u> • How will this plan link to the *Networks* Monitoring and Evaluation Plan? • Who will design and implement a monitoring and evaluation plan? Who will be responsible for it? • How can the stakeholders be included in the monitoring and evaluation? How can we foster ownership? How can we ensure that the stakeholders can learn from this and use the data to make their interventions more effective? • What are the resources needed to design and implement an effective monitoring and evaluation plan? • What resources exist within the participating organizations and groups to design and implement an effective monitoring and evaluation plan? How can these resources be mobilized?
6) Determine the technical assistance	• What are the technical assistance needs to implement the behavior change

Steps:	Key Questions to Address:
needs:	intervention strategy? (See Step #4) • What are the available resources? How will these resources be accessed? • Who will be responsible for coordinating the technical assistance as needs arise?